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MANDATORY TREATMENT FOR PRENATAL SUBSTANCE ABUSE: THE NEED TO RE-EVALUATE ITS POTENTIAL TO PROMOTE THE BEST INTERESTS OF WOMEN AND CHILDREN

BY

JILL L. MASON ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of **MASTER OF LAWS.**

FACULTY OF LAW

Edmonton, Alberta
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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Mandatory Treatment for Prenatal Substance Abuse: The Need to Re-evaluate its Potential to Promote the Best Interests of Women and Children" by Jill L. Mason in partial fulfillment for the degree of Master of Laws.

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ABSTRACT

The recommendations and conclusions developed in this thesis are in response to the demand by a majority of the Supreme Court of Canada in *DFG*[1] that the legislature address the issue of legal protection for the unborn child from substance abuse during pregnancy. In the wake of *DFG*, the misconception that legislation providing legal protection for the unborn child cannot withstand *Charter*[2] review has now been dispelled. What remains is the controversy concerning mandatory treatment for prenatal substance abuse. Accordingly, this study identifies and analyzes the factors which have contributed to this controversy, and, ultimately obstructed an objective evaluation of the potential of mandatory treatment for prenatal substance abuse to promote the best interests of women and children in rare and extreme cases.

The adversarial view of the maternal/fetal relationship, developed largely as a result of "rights talk"[3] and the "legacy of the abortion debate,"[4] has had a critical role in promoting the widely held misconceptions concerning mandatory treatment for prenatal substance abuse. It is indisputable that prevention initiatives must be directed at

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[1] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) [hereinafter *DFG* cited to [1997] S.C.J. No. 96 (QL)].

[2] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

[3] M.A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (NewYork: The Free Pres, 1991) at 171.

[4] P. King, "Helping Women Helping Children" (1992) 69 The Milbank Quarterly 595 at 604 [hereinafter "Helping Women"].

"counselling, rehabilitation, outreach and support services designed specifically to meet the needs of pregnant women with drug/alcohol addictions."[5] However, "the fact is that many addicts do not enter the treatment system unless they are forced to do so."[6] Canada must therefore broaden its perspective of mandatory treatment from the typical "women's rights" versus "fetal rights" debate and refocus law reform initiatives to a broad based multi-disciplinary understanding of the "ravages of addiction"[7] on the lives of women and children. In so doing, we must critically evaluate the potential of "pregnancy specific" legislative schemes providing for the involuntary commitment for alcohol or drug treatment for substance abusing pregnant women such as those operating in Minnesota[8] and South Dakota.[9]

Chapter two examines the area of law labeled "maternal/fetal conflict," which is the label applied to circumstances involving an alleged conflict between the decisions or actions of pregnant women and the interests of her fetus, or the state interest in protecting the life or health of the fetus.[10] The author argues that this label is not an appropriate characterization of the problem of substance abuse during pregnancy. It must be recognized that intervention to prevent substance abuse during pregnancy is not a reflection of the "view that pregnant women are the means to an end - the birth of healthy children"[11] nor does it deny their existence as an autonomous individuals with legal and constitutional rights in a manner that is "dangerous to the rights and autonomy of all women."[12] Rather, mandatory treatment in extreme cases has the potential to promote the well-being of severely addicted women by helping them recover from the bondage of addiction and actually experience autonomy and freedom of choice. In so doing, the interests of future members of our society are protected and promoted. Mandatory treatment in severe cases may be viewed as crisis intervention with the potential to break the self-perpetuating cycle of addiction, dysfunctional parenting skills, child abuse and debilitating social circumstances.[13]

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[5] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) at 964 [hereinafter "Report"].

[6] J. Platt et. al., "The Prospects and Limitations of Compulsory Treatment for Addiction" (1988) 18 (4) The Journal of Drug Issues 505 at 511.

[7] *DFG, supra* note 1 at para. 5.

[8] Minn. Stats. Ann. § 235b.02 (West 1982 & Supp. 1991) &; Minn. Stats. Ann. § 626.5561 (West 1996).

[9] S.D. Codified Laws §34-20A-63 & § 34-20A-70 (Michie: 1996 & Supp. 1998).

[10] B.R. Furrow et. al. (St. Paul, Mn: West Publishing Co., 1995) 809.

Chapter three is a detailed examination of the *DFG* case, with an emphasis on the decision of the Supreme Court of Canada. This study illustrates that the majority's demand for the legislature to address the problem of substance abuse during pregnancy is entirely justifiable. It also supports the minority view that legislative inaction "is not an excuse for the judiciary to follow the same course of inaction."[14] The study concludes that the most important contribution of the *DFG* case is that it serves as a "wake-up" call of the need for legislative intervention to prevent substance abuse during pregnancy in a manner that is focused on the "ravages of addiction" rather than on a battle between women's right to autonomy and freedom of choice versus the need to provide legal protection to the unborn child.

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[11] Report, *supra* note 5 at 959.

[12] *Ibid.*

[13] Helping Women, *supra* note 4 at 601.

[14] *DFG*, *supra* note 1 at para. 138.

Chapter four is a critical analysis of the recommendations of the Royal Commission on New Reproductive Technologies [hereinafter "the Commission"] to prohibit judicial intervention during pregnancy. It argues that these recommendations are premature and based on debatable legal and ethical reasoning. Accordingly, the author concludes that there is now an urgent need for the development of alternative legislative proposals to address the glaring inadequacies of the recommendations of the Commission. In so doing, Dr. Scorsone's dissenting opinion must be critically evaluated for its potential to contribute to law reform initiatives. In particular, Canadians must address the question she posed:[15]

> ...of whether severe drug addiction resulting in incoherence or uncontrollable compulsion is sufficiently parallel to or cognate with severe mental illness in some respects that similar approaches are appropriate.

---

[15] Report, *supra* note 5 at 1127.

DEDICATED TO MY FAMILY AND FRIENDS WHO HELPED ME
WITH THE CHILDREN AND HOME RESPONSIBILITIES
WHILE COMPLETING THIS THESIS

Acknowledgment

First and foremost, thank-you to Professor Bruce Elman for his excellent supervision of this thesis.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW

> This is not a story of heroes and villains. It is the more prosaic but all too common story of people struggling to do their best in the face of inadequate facilities and the ravages of addiction. - Justice McLachlin [1]

I. STATEMENT OF THE PROBLEM

This study examines the issue of what is the appropriate legal response to those highly controversial situations which arise when a woman with a severe addiction problem refuses treatment and continues to abuse substances during a pregnancy that will likely be carried to term. There is no question that prevention of substance abuse during pregnancy must focus on "counselling, rehabilitation, outreach, and support services designed specifically to meet the needs of pregnant women with drug/alcohol addictions."[2] However, this study argues that there are sound reasons for further examining the potential of mandatory treatment for prenatal substance abuse to both promote recovery from addiction and reduce the risk of life-long harm to future members of society in narrowly defined circumstances. While it is beyond the scope of this study to propose specific legislative reform, its objective is to develop recommendations that will direct and enhance law reform initiatives.

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[1] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) at para. 5 [hereinafter *DFG* cited to (1997) S.C.J. No. 96 (QL)].

[2] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) 949 at 965 [hereinafter "Report"].

The controversy concerning mandatory treatment for prenatal substance abuse may be attributed, in part, to the adversarial view of the maternal/fetal relationship which has been widely promoted by interest groups, the media, academics and politicians. Discussions concerning mandatory treatment are typically boiled down to a contest between a mother's right to autonomy, equality, and "freedom of choice" versus "fetal rights." The potential for mandatory treatment to promote human dignity and the best interests of both mother and her unborn child has not been thoroughly and objectively examined. Rather, the discourse has been dominated by the misconception that mandatory intervention necessarily reinforces patriarchal responses to child-bearing and child-rearing and thereby further stigmatizes already disadvantaged groups. The result is that reasoned discussions concerning mandatory treatment for prenatal substance abuse have been the exception and debates resulting in a gridlock of competing interests have been the norm.

"Rights talk" has had a critical role in the development of this unrealistic and counterproductive understanding of the maternal/fetal relationship and mandatory treatment for prenatal substance abuse. The preliminary challenge for law reformers is, therefore, to refine the "new rhetoric of rights" which "is presently less about human dignity and freedom than about insistent, unending desires."[3] The refined dialogue must promote "creative long-range thinking"[4] about mandatory treatment that includes "the moral, the long-term, and the social implications"[5] of this issue. It must be modified in a way that facilitates the "processes of public justification, communication, and deliberation."[6] Fundamental to this refined dialogue is the understanding that stakeholders on either side of the debate are neither "heroes" nor "villains." Rather, they are concerned, well intentioned and often highly qualified individuals "struggling to do their best in the face of inadequate facilities and the ravages of addiction."[7]

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[3] M.A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: The Free Press, 1991) at 171 [hereinafter *Rights Talk*].

[4] *Ibid.*

[5] *Ibid.*

Long range thinking about mandatory treatment for prenatal substance abuse directs policy-makers to focus on prevention and the root causes of addiction which are widely recognized as debilitating and self-perpetuating social circumstances. This focus directs an examination of the potential for mandatory treatment to interrupt the intergenerational cycle of addiction by strengthening parenting skills and the family unit. It is generally acknowledged that the dysfunctional parenting styles associated with substance abuse are a significant cause of child abuse. Furthermore, abused children are at risk of developing substance addiction problems.[8] The knowledge that intervention to prevent and treat substance abuse during pregnancy will benefit future generations by interrupting the self-perpetuating nature of addiction compels us to thoroughly examine creative solutions, including mandatory treatment for prenatal substance abuse.

The importance of community and the family unit in the prevention and treatment of addiction cannot be underestimated. Research challenging the traditional concepts of addiction has identified the one factor, "causing more addiction than any other, more ill health than any other, ...is the deterioration of community."[9] This view is consistent with

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[6] *Ibid.*

[7] *DFG, supra* note 1.

[8] P. King, "Helping Women Helping Children" (1992) 69 The Millbank Quarterly 595 at 601 [hereinafter "Helping Women"].

[9] S. Peele, "Challenging the Traditional Addiction Concepts" in P. Vamos and P. Corriveau eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 251 at 261.

Professor Glendon's concern that "rights talk" has promoted "an image of the rights-bearer as a radically autonomous individual"[10] and thereby neglected the critically important "social dimensions of personhood."[11] Families, neighborhoods, religious associations and other communities are described by Professor Glendon as the "the seedbeds of civic virtue"[12] upon which individual freedom and the general welfare of society ultimately depend. It follows that policy-makers are well advised to examine the potential for mandatory treatment to be accomplished in a manner that nurtures the "seedbeds" fundamental to individual freedom and the general welfare of society.

In Canada, as we approach the end of the twentieth century, there is a high level of political and public demand to prevent substance abuse during pregnancy. The recent and highly publicized decision of the Supreme Court of Canada in *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.),*[13] from which this thesis topic was born, is perhaps the single most influential factor contributing to the issue of mandatory treatment for substance abuse becoming a priority on Canada's political agenda. This decision highlighted both the devastation caused by the "ravages of addiction"[14] during pregnancy, and the inadequacy of existing the legal frameworks to respond to this problem. It also represented the strongest request ever - almost equivalent to a demand - from the Supreme Court of Canada for the legislature to address the issue of legal protection for the unborn child. The decision, it appears, has left the legislatures with no choice but to finally respond to one of the most controversial issues of the century.

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[10] *Rights Talk, supra* note 3 at 109.

[11] *Ibid.*

[12] *Ibid.* For a further discussion of this concept please refer to M.A. Glendon & D. Blankehorn eds., *The Seedbeds of Virtue* (New York: Madison Books, 1995).

[13] *DFG, supra* note 1.

[14] *Ibid.*

The 1993 Report of the Royal Commission on New Reproductive Technologies (hereafter "the Commission") recommending that judicial intervention "in pregnancy and birth not be permissible"[15] is also a major contributing factor to the high profile which substance abuse during pregnancy enjoys on Canada's political agenda. The Commission's reasons in support of these recommendations are arguably an example of the downside of "rights talk." The Commission failed to present a balanced perspective of critical issues such as a woman's right to autonomy and equality versus the need to provide legal protection for the unborn child from prenatal substance abuse. Rather, it relied on a "stark, simple rights dialect"[16] and, thereby, impeded "reasoned discussion and compromise."[17] In view of the absolute and final nature of the Commission's recommendations, and in view of that fact that the Commission arguably failed to adequately examine the issue of mandatory treatment for prenatal addiction, there is now an urgent need to re-examine the issue of mandatory treatment for prenatal substance abuse.

In addition to these critical developments, the last two decades have been marked by a growing awareness, that, despite all that has been said about substance abuse during pregnancy, the problem continues to worsen. Although the nation-wide "war against drugs" in the 1990's was marked by a focus on the prevention and treatment of prenatal substance abuse, statistics illustrate a rising rate of drug abuse amongst pregnant women and women of child bearing years. As noted by Kandall, there is a particularly high level of public concern over the increased risk of serious health impairment of addicted women and their offspring, the most serious being Aids and HIV infections which are "increasing faster among women than among men and are directly linked to intravenous drug use."[18] Perhaps one of the clearest indicators of the severity of the epidemic of prenatal substance abuse is the fact that Foetal Alcohol Syndrome [hereafter "FAS"], a condition directly caused by alcohol abuse during pregnancy, is considered "the leading preventable cause of mental disability in the western world."[19] In view of the fact that FAS[20] "is particularly an aboriginal problem,"[21] it comes as no surprise that the aboriginal child and family service agencies, responsible for delivering services to 18 First Nation communities in Manitoba, intervened in the appeal to the Supreme Court of Canada in the *DFG* case to support "the creation of a legal remedy to use in their fight against FAS/FAE."[22] These intervenors submitted to the Supreme Court of Canada that:[23]

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[15] Report, *supra* note 2 at 965.

[16] *Rights Talk, supra* note 3 at 171.

[17] *Ibid.*

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[18] S. Kandall, *Substance and Shadow* (Cambridge: Harvard University Press, 1996) at 287.

[19] The Manitoba Children and Youth Secretariat in *Strategy Considerations for Developing Services for Children and Youth* (March 1997) as cited in *DFG, supra* note 1 at para. 88. For an enlightening view of FAS, please refer to a book self-published by Dr. Gideon Koren, a professor of pediatrics, pharmacology and medicine at the University of Toronto, and director of the Motherisk Program at the Hospital for Sick Children, entitled *The Children of Neverland,* (Toronto: The Kid in Us Ltd., 1997). A summary of this book may be found in "The Children of Neverland: The silent human disaster," *The Medical Post,* 15 July 1997, at 83. Dr. Koren is cited in this article as stating "It gradually dawned on me that there is an ever- increasing group of youngsters who will not make it in our society and many of the reasons why they won't make it are preventable." He is further cited for stating "Many thousands of kids in this country and the world over will end up in Neverland and not exhaust their potential, and any single child who does not exhaust his potential is a loss to humanity- any lack of achievement is a lack of achievement for all of us."

[20] The conditions of FAS and Foetal Alcohol Effects [hereinafter "FAE"] are discussed further in chapter three.

[21] *DFG, supra* note 1 at paragraph 88.

[22] *Ibid.*

> such a remedy would be consistent with the aboriginal world view, and that the common law should be expanded to help alleviate what is particularly an aboriginal problem.

Finally, there have been two recent developments in the United States indicating the need for Canadians to further examine the potential for mandatory treatment for prenatal substance abuse to promote the best interests of severely addicted pregnant women and their unborn children. First, the state of South Dakota passed legislation effective July 1, 1998, which provides for the involuntary commitment for alcohol or drug treatment of pregnant substance abusing women.[24] This legislation follows comprehensive legislation passed in Minnesota in 1989 and 1990 enacted to facilitate the early identification of, and voluntary treatment services to, drug abusing pregnant women.[25] Civil commitment under the Minnesota scheme is sought only if the woman rejects the recommended services or fails treatment.[26]

Second, in May, 1998, the U.S. Supreme Court, in *Whitner* v. *South Carolina,*[27] did not overturn the conviction of Cornelia Whitner for criminal child neglect under state child-abuse laws, for causing her baby to be born with cocaine metabolites in its system. This decision was a departure from a series of decisions which have refused to apply state child-abuse laws to the viable fetus. There can be no doubt that this decision will be widely criticized. However, there are many others that will support this approach and argue that the U.S. Supreme Court is finally responding to the concern described by Wilson that "the moral order that once held the nation together has become unraveled."[28] Wilson argued that one way the law could respond to this concern would be to reward "the controlled or recovering drinkers and penalize the uncontrolled, self-indulgent ones."[29] To do otherwise is to contribute to concern that personal responsibility and accountability have "withered under the attack of personal self-indulgence."[30] This unprecedented decision of the U.S. Supreme Court may well encourage those who favor intervention directed at rehabilitation and harm reduction, as opposed to criminal prosecution, to re-evaluate the potential for mandatory treatment to promote the best interests of both pregnant women and their unborn children.

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[23] *Ibid.*

[24] S. D. Codified Laws § 34-20A-63 (Michie: 1996 & Supp. 1998); and S.D. Codified Laws § 34-20A-70 (Michie: 1996 & Supp. 1998).

[25] Minn. Stats. Ann. § 626.5561 (West 1996). For an excellent discussion of "Minnesota's Answer" please refer to M. Lencewicz, "Don't Crack the Cradle: Minnesota's Effective Solution For The Prevention of Prenatal Substance Abuse-Analysis of Minnesota Statue Section 626.5561" (1994) 63 Rev. Jur. U.P.R. 599 [hereinafter "Minnesota's Answer"].

[26] Minn. Stats. Ann. § 235b.02 (West 1982 & Supp. 1991).

[27] *Whitner* v. *South Carolina,* (1998) W.L. 130868 (U.S.S.C.). That case involved a motion of the National Association of Alcoholism and Drug Abuse Counselors, et al. for leave to file a brief as *amici curiae* which was granted. The petition for a writ of *certiorari* was denied in respect of the decision of *Whitner* v. *The State* 492 S.E.2d 777 (Oct. 27, 1997), which concluded that criminal intervention to prevent substance abuse during pregnancy is defensible under state child abuse laws, even if not defined to specifically include the unborn child. The decision of the South Carolina Supreme Court

II. ORGANIZATION OF THESIS

The three chapters following this introductory one are individual essays directed at providing a foundation from which broad-based, comprehensive conclusions and recommendations may be developed concerning mandatory treatment for substance abuse during pregnancy. The recommendations and conclusions are summarized in chapter five.

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will be examined in further detail in chapter two.

[28] J.Q. Wilson, *Moral Judgment* (U.S.A.: Basic Books, 1997) at 1 [hereinafter *Moral Judgment*].

[29] *Ibid.* at 31-32.

[30] *Ibid.* at 1.

Chapter two examines "maternal/fetal conflict," the label applied to circumstances where there is an apparent conflict between the behavior or decisions of pregnant women and the well-being of their unborn children. Typically, the courts are called upon to protect the best interests of the unborn child in situations involving either prenatal substance or a woman's refusal to consent to a Cesarean section deemed necessary by the medical profession. Unfortunately, the courts and scholars have inappropriately approached these highly distinct circumstances in a similar manner and thereby impeded the development of effective solutions to the epidemic of prenatal substance abuse.

Chapter three is a detailed examination of the *DFG* case, with an emphasis on the decision of the Supreme Court of Canada. The analysis illustrates that the invocation of legal mechanisms, not specifically intended to address substance abuse during pregnancy, have been largely ineffective and counter-productive. It also illustrates that the majority's demand for the legislature to address the problem of substance abuse during pregnancy is entirely justifiable. However, the analysis also supports the minority view that legislative inaction "is not an excuse for the judiciary to follow the same course of inaction."[31] Ultimately, the study concludes that the most significant contribution of the *DFG* case is that it serves as a "wake-up" call of the need to refine the way we talk and think about the maternal/fetal relationship, and, in particular, the issue of mandatory treatment for prenatal substance abuse. It is now beyond issue that the legislature must respond to the epidemic of prenatal substance abuse. However, their efforts to do so will continue to result in a gridlock of competing interests in the absence of a refined dialogue that promotes "serious and sustained political discussion."[32]

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[31] *DFG, supra* note 1 at para. 138.

Chapter four is a critical examination of the Commission's recommendations to prohibit judicial intervention during pregnancy. The chapter commences with a brief discussion of the controversial aspects of the Commission's composition, decision-making and research processes. The recommendations to prohibit judicial intervention during pregnancy are then analyzed in the context of the Commission's ethic of care and eight guiding principles. This analysis highlights the Commission's "selective exaggeration and omission,"[33] particularly in context of the dissenting opinion of Dr. Scorsone. Ultimately, the author adopts Dr. Scorsone's position that there has not been sufficient reflection on many of the complex issues raised by mandatory treatment for prenatal substance abuse to warrant the absolute prohibition on judicial intervention recommended by the Commission.

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[32] *Rights Talk, supra* note 3 at x.

[33] *Ibid.* at 175.

CHAPTER TWO

RETHINKING "MATERNAL/FETAL CONFLICT"

> A rights-based approach that pits woman against fetus fails to capture the essential biological and emotional reality of pregnancy. The fetus is in the woman's body and part of the woman's body. It is simultaneously self and not-self. Most fundamentally, however, the maternal-fetal relationship is an interconnected and interactive *unit*.[1]

I. INTRODUCTION

"Maternal/fetal conflict" is the label applied to circumstances involving an alleged conflict between the decisions or actions of a pregnant woman and the interests of her fetus, or the state's interest in protecting the life or health of the fetus.[2] This area of law reflects the approach of the Courts, scholars, and policy makers to issues concerning the maternal/fetal relationship. It also influences policy makers' perceptions of the maternal/fetal relationship, and, ultimately, the effectiveness of law reform directed at the prevention of substance abuse during pregnancy.

As the author pondered over the widely divergent opinions concerning this complex and controversial area of law, it became apparent that law reformers must develop an understanding of how and why the maternal/fetal relationship has become to be viewed as adversarial. In so doing, they must address the question of whether the "maternal/fetal conflict" label is appropriately applied to the highly distinguishable situations which generally fall under its umbrella. Do the interests of the severely addicted pregnant woman and her unborn child truly conflict in circumstances when the mother has decided to continue the pregnancy to term? This question is particularly compelling when we consider not only the high risk of permanent and severe life-long damage to the unborn child, but also the dysfunctional parenting skills typical of individuals suffering from addiction and the resulting intergenerational nature of addiction.

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[1] P. King, "Helping Women Helping Children" (1992) 69 The Milbank Quarterly 595 at 617 [hereinafter "Helping Women"].

[2] B.R. Furrow et. al., *Health Law* (Minnesota: West Publishing Co., 1995) at 809 [hereinafter *Health Law*].

The overview that follows illustrates that the concept of "maternal/fetal conflict" has been significantly shaped by what Professor Glendon describes as "rights talk"[3] and by what Professor King describes as the "legacy of the abortion debate."[4] Examination of these concepts provides insight into why one of the most natural and necessary relationships known to mankind has come to be viewed as adversarial. It also provides a basis for developing a more constructive and realistic view of the maternal/fetal relationship and mandatory treatment for prenatal substance abuse.

The importance of how we deal with the problem of substance abuse during pregnancy goes beyond the issue of whether future citizens will have to bear the life-long burden of the direct results of prenatal substance abuse such as Foetal Alcohol Syndrome [hereafter "FAS"]. The "major national crisis"[5] caused by the deterioration of child-raising households and the related concern "that many of the nation's children will never have a chance to develop their full potential as human beings"[6] is also caused, in part, by the high prevalence of addiction related problems in our society. As a representative of a prominent Alcoholism and Drug Abuse Committee noted:[7]

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[3] This term was taken from M.A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: The Free Press, 1991) [hereinafter *Rights Talk*].

[4] Helping Women, *supra* note 1 at 604.

[5] M.A. Glendon, *Seedbeds of Virtue* (New York: Madison Books, 1995) [hereinafter *Civic Virtue*].

[6] *Ibid.*

[7] S. Sanduski, "Policy Development for Women and Children's Drug Treatment

> ...the problems of drug-dependent women and children are replete with controversy and uncertainty. That we have not evolved to keep pace with the needs of this population forces us to look ahead. Clearly, we pay now or pay later. Investing in programs that have the potential to break the intergenerational cycle of addiction offers our best hope.

This chapter commences with a brief overview of the *DFG* case which was recently decided by the Supreme Court of Canada.[8] The decision provides an excellent context for examining issues related to "maternal/fetal conflict" and substance abuse during pregnancy.

The broad range of circumstances generally encompassed within the area of law labeled "maternal/fetal conflict" are then described: from enforced Cesareans and enforced *intra-utero* surgery to substance abuse during pregnancy. The question arises as to whether "maternal/fetal conflict" is an appropriate label for the problem of substance abuse during pregnancy.

The legal remedies typically invoked to compel medical treatment or control a pregnant woman's lifestyle "choices" are then reviewed. Serious inadequacies in the existing legal frameworks are identified. It is clear that *ad hoc* extension of existing law is an inappropriate remedy for this complex medical and social problem.

An overview of selected scholarly opinions representing the highly polarized positions concerning the appropriate response to situations of alleged "maternal/fetal conflict" then follows. These opinions may be generally categorized as advancing

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Services" in P. Vamos & P. Corriveau, eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 421 at 422.

[8] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) [hereinafter *DFG* cited to (1997) S.C.J. No. 96 (QL)].

reproductive autonomy and freedom of choice of pregnant women versus the need for state intervention to provide legal protection of the unborn child.

The chapter concludes with a brief discussion of potentially new direction for policy makers that is refocused from a rights based approach to an understanding of the maternal/fetal relationship as an interconnected and interactive unit.

II. OVERVIEW OF *DFG*

The *DFG* case concerned Ms. G., a twenty-two year old, single, Aboriginal, pregnant woman who suffered from a chronic and severe glue sniffing addiction. Winnipeg Child and Family Services, (hereinafter "the Agency"), had obtained permanent orders of guardianship of Ms. G.'s first three children before they were two years old. Two of her children were born addicted to chemicals and all three were developmentally delayed as a result of her chemical dependency during pregnancy.

The facts of the case reveal the typically harmful effects of substance abuse not only on the unborn child, but also on individuals suffering from chronic and severe addiction. In December, 1990, at the age of 16 years, Ms. G. was deemed a "child in need of protection" and placed in a residential youth treatment facility. At the time, she was pregnant with her first child, abusing solvents, and engaged in an unstable lifestyle. She was subsequently placed in a residential facility designed to assist young mothers with the care of infants.[9] However, Ms. G. was unable to alter her lifestyle and continued to suffer from addiction problems and general instability. Frequently, when visited by social workers, her apartment had a strong odor of glue and Ms. G. showed classic signs of impairment. She prostituted to support her addiction and had attempted suicide on several occasions. In May, 1996, Ms. G. went to the hospital complaining of difficulty walking, loss of balance, weakness and nausea - all symptoms of chronic and severe solvent abuse. She was admitted to the Chemical Withdrawal Unit with a diagnosis of "solvent abuse with cerebellar disease and probable cognitive impairment."[10]

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[9] *Ibid* at para. 69.

Aware of Ms. G.'s fourth pregnancy and her continued chronic and severe substance abuse, the Agency applied the Manitoba Court of Queen's Bench for an order that Ms. G. attend to and remain at a place of safety and refrain from the consumption of intoxicating substances until the birth of her child. The Agency also filed a notice of motion requesting a mandatory injunction pending the trial requiring Ms. G. to enter a treatment program until the birth of her child. Finally, the Agency filed a notice of application for an order committing Ms. G. to the custody of the Agency pursuant to the *Mental Health Act*.[11]

In response to the Agency's applications, Justice Schulman of the Manitoba Court of Queen's Bench concluded:[12]

> I have found the Ms. G.'s present mental state engages the jurisdiction of this Court under the *Mental Health Act* and provides a strong *prima facie* foundation for the exercise of this Court's *parens patriae* powers.

On the basis of this conclusion, Justice Schulman ordered that Ms. G. be remanded into the custody of the Agency with authority to arrange for her treatment at two institutions. The Agency was also given authority to apply, without notice, for an order committing her for treatment if she failed to complete the course of treatment prescribed by the Agency. The order would terminate upon the birth of Ms. G.'s fourth child.

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[10] *Ibid.* at para. 75.

[11] R.S.M. 1987, c. M. 110, s. 56 [hereinafter *Mental Health Act*].

[12] *DFG*, *supra* note 8 at para. 42 cited to M.J. No. 386 (QL).

On appeal by Ms. G., the Manitoba Court of Appeal set aside the decision of Justice Schulman and dismissed the Agency's applications. In so doing, Justice Twaddle found the trial judge's conclusion that Ms. G. was mentally disordered as defined under the *Mental Health Act* was not supported by evidence.[13] He also found the evidence did not support the finding of incompetency as required for exercise of the Court's *parens patriae* jurisdiction.[14]

Having dismissed the trial judge's justification for granting the Agency's order, Justice Twaddle went on to consider whether the Agency was entitled to alternative relief. In so doing he addressed the "much more controversial question of whether the Court of Queen's Bench has authority to order the mother to undergo treatment, or to refrain from the use of intoxicants, for the protection of the unborn child."[15] The Court concluded that the *parens patriae* jurisdiction over minors does not apply until after the child is born. The Court also decided that it was not appropriate to recognize a cause of action in favor of an unborn child.[16] Justice Twaddle concluded that it was "for the legislature alone to decide what if anything needs to be done"[17] to protect the unborn child from substance abuse during pregnancy.

The Majority of the Supreme Court of Canada dismissed the Agency's appeal from the decision the Manitoba Court of Appeal. In refusing to reinstate the trial judge's order, the Court noted:[18]

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[13] *Ibid.* at para. 8 cited to M.J. No. 398 (QL).
[14] *Ibid.* at para. 10.
[15] *Ibid.* at para. 12.
[16] *Ibid.* at para. 13.
[17] *Ibid.* at para. 36.

> an order detaining a pregnant woman for the purpose of protecting her fetus would require changes to the law which cannot be properly made by the Courts and should be left to the legislature.

The Majority concluded that the law of tort and the Court's *parens patriae* jurisdiction could not provide relief until the child is born alive.

In dissent, Justices Major and Sopinka concluded that it was appropriate, in narrowly defined circumstances, to extend the Court's *parens patriae* jurisdiction to protect the unborn child from substance abuse during pregnancy. They rejected the "born alive rule" after establishing that it was a legal anachronism that was developed simply as an evidentiary presumption during a period of limited medical knowledge. With today's advanced medical technology, it no longer made sense to retain the rule where its application would be perverse.[19] They concluded that, although it may have been preferable for the legislature to act, "its failure to do so is not an excuse for the judiciary to follow the same course of inaction."[20]

III. DISTINGUISHING SUBSTANCE ABUSE DURING PREGNANCY FROM "MATERNAL/FETAL CONFLICT"

The potential for the mother's interests to conflict with the interests of the fetus, or the state's interest in protecting the life or health of the fetus, exists in three situations: health care choices, life style choices and employment choices made by pregnant women.[21] It is beyond the scope of this paper to discuss issues arising from the potential conflict between a pregnant woman's employment choices and the interests of the fetus.[22] Rather, this chapter will focus on health care and life style choices of pregnant women that are alleged to conflict with the interests of the fetus.

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[18] *Ibid.* at para. 4 cited to S.C.J. No. 96 (QL).

[19] *Ibid.* at para. 110.

[20] *Ibid.* at para. 138.

[21] *Health Law, supra* note 2.

In this section of thesis it will be established that the controversy concerning mandatory treatment for prenatal substance abuse can be minimized by distinguishing situations of judicial intervention requiring competent pregnant women to undergo invasive medical procedures solely in the best interests of the unborn child, from legal intervention to prevent substance abuse during pregnancy. Many of the arguments against state intervention in a pregnant woman's decisions concerning invasive medical treatment solely in the best interests of the unborn child are simply not applicable to intervention to prevent substance abuse during pregnancy.

The comparison of imposed Cesareans and mandatory treatment for substance abuse during pregnancy establishes that the issue of legal intervention during pregnancy must be examined in the context of critical factors such as: (1) the degree of risk to mother; (2) the degree of risk to fetus; (3) the health and competency of the mother; (4) the frequency of the risk; (5) whether the circumstances in issue add substantial value to the lives of pregnant women, i.e. is it the type of self-determination that deserves protection; and (6) whether the proposed intervention contributes to the well-being of the mother.

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[22] For a comprehensive overview of this issue see J. Fudge & E. Tucker, "Reproductive Hazards in the Workplace: Legal Issues of Regulation, Enforcement, and Redress" in Royal Commission on New Reproductive Technologies, *Legal and Ethical Issues in New Reproductive Technologies: Pregnancy and Planned Parenthood,* vol. 4 (Ottawa: Minister of Supply and Services Canada, 1993) at 161.

Cesarean sections are highly invasive procedures that involve a significant risk to the mother. Often they are performed solely in the best interests of the unborn child. Enforced Cesareans, generally, arise at the time of birth in emergency circumstances. Generally, the mother's refusal to consent is not associated with incompetency but rather it is a result of conflicting values or desires or simply from the pressure of emergency circumstances. The circumstances giving rise to the issue of enforced Cesareans are relatively rare.

On the contrary, treatment for substance abuse during pregnancy is not invasive and the risks to the mother are minimal. Treatment for chronic and severe substance addiction is in the best interests of both mother and unborn child. The mother's competency to make choices concerning substance abuse is seriously jeopardized because of the addiction. Substance addiction is not a condition that arises because of the pregnancy. It can arise at any time and generally remains an issue for the individual's entire life. Substance addiction is passed from generation to generation and is associated with debilitating social circumstances.[23] Substance addiction occurs at an epidemic rate. Presently, "fetal alcohol syndrome is the leading known cause of mental retardation in the United States."[24]

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[23] Helping Women, *supra* note 1 at 599-601.

[24] *DFG, supra* note 8 at para. 88. The term "epidemic" is used in this thesis in a manner consistent with its dictionary definition as being a disease arising from a widespread cause which affects many people at the same time in the same country. It is also used in a manner that is consistent with its use by professionals specializing in addiction. For example, the president of the international conference,"Drugs and Society to the Year 2000," referred generally to the "drug epidemic" in his opening address. He described how Canada established the LeDain Commission in the 1960's in response to the crisis brought about by the beginning of the "drug epidemic." He later decribed drug abuse as amounting to a world wide crisis of epidemic proportions. See P. Vamos & P. Corriveau, eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for

The fact that the issue of state intervention to prevent substance abuse during pregnancy must not be addressed on the same grounds as state intervention to enforce invasive medical procedures or treatment of competent pregnant women solely in the best interests of the unborn child is exemplified by comparing a controversial and highly publicized enforced Cesarean case to the *DFG* case.

Re A.C.[25] involved the imposition of a Cesarean section on Angela Carder who was dying of cancer. This decision was made despite the fact that it was predicted that the operation would hasten Ms. Carder's death, and neither she nor her mother conented to the operation.[26] The trial decision was made on the basis that the fetus was viable and therefore the state had an "interest in protecting the potentiality of life."[27] The baby died shortly after surgery and Ms. Carder died two days later.

On appeal, the Court ruled that pregnant women have a constitutionally protected right to make health care decisions on their own behalf and on behalf of their fetus. The issue of whether or not the patient was competent to make her own health care decisions was to be determined by the Court.[28] If the patient was determined to be incompetent, the

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Drug Dependencies Inc., 1992) 39-41.

[25] *Re A.C.*, (1987) 533 A. 2d 611, (1990) 573bA. 2d 1235 [hereinafter *Re A.C.*].

[26] S. McLean, ed., *Contemporary Issues in Law, Medicine and Ethics* (Aldershot: Dartmouth Publishing Co., 1996) 79 at 85 [hereinafter *Contemporary Issues*]. For additional discussions of this case see S. Rodgers, "Juridical Interference with Gestation and Birth" in Royal Commission on New Reproductive Technologies, *Legal and Ethical Issues in New Reproductive Technologies,* vol. 4 (Ottawa: Minister of Supply and Services Canada, 1993) 1 at 69-70. For general discussions of enforced Cesareans see: N. Rhoden, "The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans" (1986) 74 California Law Review 1951; G. J. Annas, *Standard of Care* (New York: Oxford University Press, 1993) at 35.; B. Furrow, S. Johnson, T. Jost, R. Schwartz et. al., *Bioethics: Health Care Law and Ethics* (Minnesota: West publishing Company, 1991) 146 [hereinafter *Bioethics*].

[27] *Ibid. Contemporary Issues* at 85.

[28] *Re A.C., supra* note 25 at 1247.

substituted judgment process should be utilized.[29] The result was that the trial decision was overturned because it failed to follow the substituted judgment process.

Significant controversy developed following the Appeal Court's decision. As summarized by Rodgers:[30]

> Following the decision of the Court of Appeal, litigation claiming deprivation of human rights, discrimination, wrongful death, malpractice, and other claims was resolved in an out-of-court settlement in favor of Ms. Carder's family and estate. Part of the settlement required development of policies at the hospital level affirming the autonomy of pregnant patients and incorporating the decision of the Court of Appeal that 'in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant woman - on behalf of herself and the fetus.'

In contrast to Ms. Carder's tragic story, the proposed mandatory treatment for Ms. G.'s severe addiction problem was not invasive, nor was it solely in the best interests of the unborn child. Substance addiction had become a life threatening condition for Ms. G.. She clearly needed assistance to recover from this illness. Once mandated for treatment, Ms. G. subsequently remained in treatment voluntarily. The evidence at the date of the hearing before the Supreme Court of Canada was that Ms. G. no longer abused substances.[31] It is indisputable the Ms. G.'s circumstances were highly distinguishable from those of Ms. Carder. It, therefore, makes little sense to apply conclusions from Ms. Carder's case to circumstances involving chronic and severe substance abuse during pregnancy in the absence of a critical examination of the rationale for doing so. Unfortunately, *Re A.C.* has been widely utilized to illustrate the "detrimental impact of prenatal judicial intervention on women's autonomy and integrity"[32] generally, and thereby advance the view that judicial intervention should not be permitted.[33]

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[29] *Ibid.*

[30] Rodgers, *supra* note 26 at 71.

[31] *DFG, supra* note 8 at para. 87 cited to S.C.J. No. 96 (QL).

[32] R. Bell, "Prenatal Substance Abuse and Judicial Intervention in Pregnancy *Winnipeg Child and Family Services v. G. (D. F.)*" (1997) 55 U.T. Fac. L. Rev. 321 at

There is also a need to distinguish the wide range of lifestyle choices that may give rise to "maternal/fetal conflict." There are many lifestyle choices that a pregnant woman may make that place her fetus at risk including alcohol and drug abuse, smoking, excessive exercise, lack of exercise, skiing, and a host of other activities.[34] In fact, many commentators are concerned that as medical technology heightens our understanding of these risks, women will be held to an unacceptably high duty of care in relation to their fetus.[35] Unfortunately, these unrealistic "slippery slope" arguments, suggesting that once women are held accountable for any lifestyle choices adversely affecting the fetus they could be held to an unacceptably high duty of care, are over used and often counter productive. They fail to consider the fact that it is well established that the legislature does address extreme circumstances involving complex social problems. However, it does not follow that less extreme circumstances will be regulated. Professor King, when

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340 [hereinafter "Case Comment DFG"].

[33] For example see R. Sturgess, "In Re A.C.: A Court-Ordered Cesarean Becomes Precedent For Nonconsensual Organ Harvesting" (1988-89) 13 Nova Law Review 649-671. The title of this article reflects the degree of controversy arising from this case.

[34] R. Blank, "Maternal-Fetal Relationship: The Courts and Social Policy" (1993) 14 Health Law at 65. [hereinafter "Blank"].

[35] For example see D. Johnson, "The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection" (1986) 95 Yale L. J. 599 at 606. In this article, Johnson expressed the concern that pregnant women could be held liable:

> ...for any behavior during her pregnancy having potentially adverse effects on her fetus, including failing to eat properly, using prescription, non prescription and illegal drugs, smoking, drinking alcohol, exposing herself to infectious disease or to workplace hazards, engaging in immoderate exercise or sexual intercourse, residing at high altitudes for prolonged periods, or using a general anesthetic or drugs to induce rapid labor during delivery.

challenging the "slippery slope" argument concerning lifestyle choices, commented that "while the law forbids child abuse or neglect, it also tolerates conduct that virtually everyone would consider bad parenting because the law is reluctant to intervene in the family."[36] Similarly, while mental health legislation authorizes mandatory confinement of people suffering from severe mental illness which renders them a danger to themselves or others, it does not follow that people with less severe mental illness may be confined against their will.

The lifestyle choice issue was considered by the Supreme Court of Canada in the *DFG* case in the context of the "familiar slippery slope" argument. The Majority and the Minority in that case disagreed as to whether the slippery scope argument justified a bar to extending the common law to protect the unborn child from substance abuse during pregnancy. Whereas the Minority was prepared for the Courts to draw the line, the Majority concluded that no "bright line" emerged for the Courts to distinguish the various lifestyles choices, once the door was opened to holding pregnant women accountable for lifestyle choices adversely affecting the fetus.[37] However, the Majority implied that the legislature, not the Courts, could properly address specific lifestyle choices and overcome the slippery slope argument. The Court stated in this regard:[38]

> ...the legislature, should it choose to introduce a law permitting action to protect unborn children against substance abuse, could limit the law to that precise case.

In fact, it is arguable that the Majority implied that it would be appropriate to introduce laws to protect the unborn child from substance abuse during pregnancy. The Majority acknowledged that abusing solvents does not add substantial value to a pregnant woman's well-being and may not be the type of self-determination that deserves protection.[39] It also noted that alcohol and drug abuse "may be the products of circumstance and illness rather than free choice."[40]

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[36] P. King, "Should Mom be Constrained in the Best Interests of the Fetus" (1989) 13 Nova L. Rev. 406 at 409.

[37] *DFG, supra* note 8 at para 39.

[38] *Ibid.* at para. 24.

The potential for circumstances of "maternal/fetal conflict" arising from the health care choices of pregnant women will expand as techniques for fetal therapy are developed and become more universally accessible. Blank predicts that this development promises to "sharpen disagreement as to whether state intervention in reproduction decisions is ever justifiable, and if it is, under what conditions it is warranted."[41] It is, therefore, imperative that scholars and policy-makers resist making generalizations about the widely divergent circumstances which could potentially give rise to the issue of judicial intervention during pregnancy. Rather, they must focus on the particular circumstances and intervention in issue in each case.

Indeed, in Canada the disagreement as to whether state intervention in reproductive decisions is ever justifiable has escalated. On the one hand, the Royal Commission on New Reproductive Technologies (hereinafter "the Commission") has recommended an absolute prohibition on judicial intervention in pregnancy.[42] Conversely, the Majority of the Supreme Court of Canada decision in *DFG* has urged the legislature, with unprecedented repetition, to address the issue of legal intervention to prevent substance abuse during pregnancy. In so doing, it suggested that substance abuse during pregnancy was an evil to be corrected by the legislature.[43]

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[39] *Ibid.* at para. 39.

[40] *Ibid.* at para. 41.

[41] Blank, *supra* note 34 at 73.

[42] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Supply and Services Canada, 1993) 1124 at 964 [hereinafter " Report"]. For a detailed discussion of these recommendations please refer to Chapter 4 of this thesis.

The complex problem of alcohol and drug addiction is at the root of the issue of state intervention to prevent substance abuse during pregnancy. The severity of the epidemic of drug abuse has been acknowledged internationally at the highest levels of government and remains a priority on political and social agendas. In 1986, American President Ronald Reagan announced the war against drugs, stating that "Drugs are menacing our society...there is no moral middle ground."[44] Similarly, Prime Minister Brian Mulroney announced that "Drug abuse has become an epidemic that undermines our economic as well as our social fabric."[45] The Canadian government subsequently created a federal drug secretariat which developed a "new national focus on drug strategy" with objectives of reducing the harm to individuals, families and communities from the abuse of drugs. The funding projected for the first five years of this strategy was $210 million. Canada's Drug Strategy was renewed in 1992 for a further five years.[46] It is clear that the appropriate response to addiction is itself an immensely complex issue and must not be overshadowed by the controversial debates concerning the maternal/fetal relationship.

Rather than applying the politically motivated arguments arising from enforced Cesarean cases, the problem of substance abuse during pregnancy must be approached by integrating research concerning addiction with policy formation directed at the prevention and treatment of substance abuse during pregnancy. Indeed, it is becoming widely recognized that drug policies must be based on "the joint efforts of legislators, scientists and experts in social and community work."[47] Such policies must address the root causes of addiction and the intergenerational nature of addiction in particular. This entails an examination of whether addiction is a social or individual problem.[48] More and more, emphasis is being placed on addiction as a social problem. It is considered a "common manifestation of people's efforts to cope in a fast-paced and changing world."[49] It is a symptom of greater ills within our society such as a deterioration of the family unit and the community[50] which in turn are further weakened by addiction. Given the immensely complex dimensions of addiction and substance abuse during pregnancy, it seems absurd to address it as a just another circumstance of "maternal/fetal conflict."

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[43] *DFG, supra* note 8 at para. 26.

[44] P. Erickson, "Recent Trends in Canadian Drug Policy: The Decline and Resurgence of Prohibitionism" (1992) 121 Daedalus 239 at 248.

[45] *Ibid.*

[46] *Ibid.*

IV. "MATERNAL/FETAL CONFLICT" OR "MATERNAL/ FETAL WELFARE"

There is a noticeable trend in recent literature that acknowledges that "true conflicts between pregnant women and their fetuses are extremely rare."[51] Why, then, is this area of law labeled "maternal/fetal conflict"? It has been suggested that it is because of the conflict between pregnant women and their physicians.[52] In this regard, it has been noted that a "series of cases suggests that when doctors testify that a Cesarean is necessary for the health of the fetus, but the mother 'escapes' and attempts a normal vaginal birth, there is a good chance the child will be born without complication."[53] However, in the absence of reliable research - which is certainly not a "series of cases"- it is inappropriate to draw such conclusions about the medical profession, no matter how politically effective these arguments may be. Although the patient-doctor relationship may be a source of conflict in rare cases, it cannot be considered justification for the vast majority of alleged circumstances of "maternal/fetal conflict."

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[47] G. Bertolaso, "Drug Research: Impact on Public Policy" in P. Vamos & P. Corriveau, eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 307 at 308.

[48] B. Primm, "Addiction: Social Pathology or Individual Problem" in P. Vamos & P. Corriveau eds., *Drugs and Society To the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 267.

[49] J. LeCavalier, "Canada's Drug Strategy: Rising to the Challenge" in P. Vamos & P. Corriveau, *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 96.

[50] S. Peele, "Challenging the Traditional Concepts" in P. Vamos & P. Corriveau eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 251 at 261.

[51] Blank, *supra* note 34 at 810.

More commonly, it is suggested that the perceived conflict has emerged as a result of medical technology that has enabled us to view the fetus as a separate patient.[54] While this view is widely held, it is inconsistent with the fact that during the period of history when the life of the fetus was virtually a mystery, the unborn child was indeed considered a separate entity and access to abortion services was strictly regulated once the existence of the unborn child could be determined. The Salem witch trials are a striking illustration of the law's concern for the unborn child and its tendency to view the fetus as separate from its mother, despite the absence of medical technology. In 1692, six people were found guilty of witchcraft and sentenced to death. All were hanged except Elizabeth Proctor who successfully pleaded pregnancy and was, therefore, able to take refuge in the common law custom of staying execution until the child was born. This practice was justified on the basis that the child she was carrying was an innocent person.[55]

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[52] *Contemporary Issues, supra* note 26 at 80.

[53] *Bioethics, supra* note 26 at 155.

[54] Report, *supra* note 42 at 964.

[55] I. Gentles, "The Unborn Child and the Criminal Law" in I. Gentles ed., *A Time To Choose Life* (Toronto: Stoddart Publishing Company, 1990) 147 at 148.

Furthermore, the fact that the liberalization of abortion laws occurred during a period in history when there was a tremendous surge of information about fetal development as a result of technological advancements undermines the argument that our ability to understand the fetal life has resulted in the recognition of the fetus as a separate patient.

The author acknowledges that the application of the "maternal/fetal conflict" label - inappropriately in the author's view - to situations involving substance abuse during pregnancy is a result of the trend to view the maternal/fetal relationship as adversarial. However, this is more a result of "rights talk" and the "legacy of the abortion debate"[56] which have promoted an adversarial perspective of the maternal/fetal relationship than because of our ability to perceive the fetus as a separate patient.

"Maternal/fetal welfare" or "maternal/child welfare" are more accurate and useful labels for the area of law concerned with the prevention of substance abuse during pregnancy.[57] These labels reflect the actual challenge of the situation: the promotion of the best interests of both mother and unborn child. These labels also take into account the reality that the harmful influence of the mother's substance abuse problem will not terminate at the birth of the child. The physical, emotional and cognitive problems that children may suffer as a result of dysfunctional parenting skills caused by substance abuse are well established. Furthermore, the generational nature of addiction is, at least in part, a result of the dysfunctional parenting skills of substance addicted parents. Professor King's comments in this regard are particularly insightful:[58]

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[56] *Helping Women, supra* note 1 at 604.

[57] The author first considered the appropriateness of this label when reading this article: S. Anderson Garcia, "Drug Addiction and Mother/Child Welfare: Laws and Discretionary Decisionmaking" (1992) 13 Journal of Legal Medicine 129.

[58] *Helping Women, supra* note 1 at 601.

> Children who live with substance-abusing parents are also at risk of physical and emotional harm (Chasnoff 1988; Deren 1986; Hassett 1985; Rosembaum 1979). Although addicted parents do not necessarily abuse their children, many substance-abusing parents have impaired parenting skills because of their troubled childhoods and their drug-seeking lifestyles. As a result, substance abuse is frequently noted in cases of child abuse and neglect (Black and Mayer 1980; Burns and Burns 1988; Egan 1990; Mayer and Black 1977). Most children live with or are cared for by women. As a consequence, if children come into contact with a substance-abusing parent, it is likely to be their mothers. Although children, unlike fetuses, can be removed from their parents' custody if they are being abused, removal does not guarantee that the child will be protected from harm. Foster care is not realistically a vast improvement over life with an addicted parent, given the current inadequacies of our foster care system.
>
> Being parented is also the primary preparation for becoming a parent. Patterns of dysfunctional parenting seen in substance-abusing families are thus passed from generation to generation (Burns and Burns 1988). The result is an ongoing cycle of abuse and neglect leading to depression and self-degredation that, in turn, puts individuals at risk both for substance abuse as a form of self-medication and of becoming another inadequate, hurtful parent (Regan, Ehrlich, and Finnegan 1987).

In short, substance abuse during pregnancy simply does not fit the "maternal/fetal conflict" label. Although this label need not be discarded, it should be restricted to those situations determined, by careful assessment, to involve an actual conflict between the well-being of mother and unborn child. The label "maternal/child welfare" or "maternal/fetal welfare" more accurately describes the area of law concerning substance abuse during pregnancy.

V. LEGAL REMEDIES TO RESPOND TO PERCEIVED CIRCUMSTANCES OF "MATERNAL/FETAL CONFLICT"

In Canada and the United States, a variety of legal mechanisms have been relied upon to support applications to impose medical treatment or life style changes on pregnant women. While the level of activity in the United States is several times greater than in

Canada, the issues raised are similar.[59]

In Canada, only two jurisdictions have legislation directed specifically at circumstances of "maternal/fetal conflict." In the New Brunswick child welfare legislation, the term "child" is defined as including the "unborn child."[60] This legislation has been relied on to impose a six month supervisory order on a pregnant women in the best interest of her unborn child.[61]

The Yukon *Children Act*[62] provides that, where there are reasonable and probable grounds to believe that a fetus is being exposed to a serious risk of suffering from FAS, a court may order the pregnant woman to participate in supervision or counselling regarding her use of intoxicating substances. This provision was considered by the Yukon Supreme Court in the *Joe* case and held to be unconstitutional primairly because the term "Foetal Alcohol Syndrome" was not adequately defined.[63] However, it is argued that "it is implicit

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[59] Rodgers, *supra* note 26 at 89.

[60] *Family Services Act*, S.N.B. 1980, c. F-2.2.

[61] *The Minister of Health and Community Service* v. *A.D.* (1990), 109 N.B.R. (2d) 192 (Q.B.) 13.

[62] *Children's Act*, S.Y.T. 1984, c. 2. reads as follows:

> Where the Director has reasonable and probable grounds to believe and does believe that a foetus is being subjected to a serious risk of suffering from foetal alcohol syndrome or other congenital injury attributable to the pregnant woman subjecting herself during pregnancy to addictive or intoxicating substances, the Director may apply to a judge for an order requiring the woman to participate in such reasonable supervision or counseling as the order specifies in respect of her use of addictive or intoxicating substances.

[63] *Joe* v. *Y.T. (Director of Family and Children Services)* (1986), 5 B.C.L.R. (2d) 267 (Y.T.S.C.). For a further discussion of this decision see: M. Jackman, "The Canadian Charter as a Barrier to Unwanted Medical Treatment of pregnant Women in the Interests of the Foetus" (1995) 14 (1) Health Law in Canada 49 at 51. It includes this summary:

> In a brief judgment, the Yukon Supreme Court concluded "with no hesitation" that the provision infringed the pregnant woman's right to life, liberty and security of the person under s. 7 of the *Charter* because it failed to define foetal alchol syndrome. However, since the appellant had

in the judgment that the court would have been predisposed to granting an order controlling the conduct of a pregnant woman had the terms in the legislation been precisely defined."[64] This legislation has not been relied upon by child welfare authorities since the *Joe* decision and is presently under study.[65] It has not yet been amended, in part, because the ruling is considered *obiter dicta.*[66]

In the United States there has been a much higher level of legislative activity directed specifically at circumstances of alleged "maternal/fetal conflict." Unfortunately, much of this activity has been punitive in nature. For example, the crime "fetal abuse" emerged primarily as a result of an escalation of pregnant women's use of illegal drugs such as crack cocaine and heroin.[67] Prosecutions for this crime relied on "statutes on child abuse, neglect, or endangerment and delivering a controlled substance to a minor."[68] Until very recently, efforts to criminalize fetal abuse typically failed to withstand judicial scrutiny. They were generally considered to involve the extension of the criminal statutes beyond its precise language and beyond the intentions of the legislatures. Furthermore, the argument that an individual's right to due process is violated because of the lack of

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complied with the order by the time of the appeal, the Court decided that the appeal was academic.

[64] R. Bessner, "State Intervention In Pregnancy" in G. Bassen, M. Eichler & A. Lippman, eds., *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies,* vol. 2 (Hull, Que.: Voyageur, 1993) 171 at 174.

[65] M. Litman & G. Robertson, "Is a Property Regime Appropriate?" in Research Studies of the Royal Commission on New Reproductive Technologies, *Overview of Legal Issues in New Reproductive Technologies,* vol..3 (Ottawa: Minister of Supply and Services Canada, 1993) at 242.

[66] As per telephone call to Ms. Anne Sheffield, Director, Family and Children's Services, Yukon Territories (22 October 1997).

[67] K. Farr, "Fetal Abuse and the Criminalization of Behavior During Pregnancy" (1995) 41 (2) Crime and Delinquency 235.

[68] *Ibid.* at 237.

notice that drug delivery and child abuse statutes apply to prenatal behavior was typically successful. Occasionally, these prosecutions failed on the basis that the mother's right to privacy and autonomy had been violated.[69]

The recent decision of the U.S. Supreme Court in *Whitner* v. *South Carolina*[70] may indicate the beginning of a new trend in the American legal system to uphold efforts to criminalize prenatal substance abuse. There can be little doubt that significant controversy will be generated by this decision which denied, without reasons, a petition for a writ of *certiorari* of the decision of the South Carolina Supreme Court. In that case, the South Carolina Supreme Court upheld the conviction of Cornelia Whitner[71] for criminal child neglect for causing her baby to be born with cocaine metabolites in its system, even in the face of legislation that did not define the "child" to include "viable fetus."[72] The decision of Justice Toal of South Carolina's Supreme Court, thoroughly addressed, and ultimately rejected the arguments which, in the past, have typically resulted in the failure of prosecutions involving prenatal substance abuse. This decision will therefore be examined in some detail.

In April, 1992, Whitner pled guilty to criminal child neglect under the *Children's Code* for causing her baby to be born with cocaine metabolites in its system. The circuit court judge sentenced her to eight years in prison. Whitner did not appeal the conviction but later filed a petition for post conviction relief. The petition was granted on the grounds:[73]

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[69] N. Schiff, "Legislation Punishing Drug Use During Pregnancy: Attack on Women's Rights in the Name of Fetal Protection" (1991) 19 Hastings Constitutional Law Quarterly 197 at 205.

[70] 118 S.Ct. 1857 (1998).

[71] *Whitner v. The State*, 492 S.E. 2d 777 (1997) [hereinafter *Whitner*].

[72] South Carolina *Children's Code*, S.C. Code Ann. s. 20-7-50 (1985) [hereinafter "*Children's Code*"].

i) she had ineffective counsel because her lawyer did not advise her that the statute under which she was prosecuted might not apply to prenatal drug use; and
ii) the circuit court's lack of subject matter jurisdiction to accept her guilty plea.

Justice Toal allowed the State's appeal of the circuit court judge's decision granting the petition for post conviction relief. He concluded that the post conviction court erred in finding that the sentencing circuit court lacked subject matter jurisdiction to accept Whitner's guilty plea. Criminal child neglect under the *Children's Code* includes an expectant mother's use of crack cocaine after the fetus is viable because it is a "person" for the purposes of the *Children's Code*.[74]

Justice Toal supported this conclusion by examining principles concerning judicial interpretation of a statute. He declared that the language of the particular clause must be construed in conjunction with the purpose of the whole statute and the policy of the law.[75] Furthermore, he applied the basic presumption that the legislature has knowledge of previous legislation and judicial decisions construing that legislation when later statutes are enacted concerning related subjects.[76]

Justice Toal then examined these general principles in the context of relevant case law. He referred to the decision in *Hall* v. *Murphy*[77] which addressed the issue of whether an infant who died shortly after birth from injuries sustained as a viable fetus was a person within the purview of a wrongful death statute. The South Carolina Supreme Court rejected the argument in that case that the fetus was not a person within the meaning of that statute on the basis that a fetus has no separate being apart from the mother.[78] Rather, it was concluded that the exclusion from recovery on the basis of that argument was "unsound, illogical and unjust."[79] In short, the *Hall* decision was cited to support the view that "South Carolina law has long recognized that viable fetuses are persons holding certain legal rights and privileges."[80]

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[73] *Whitner, supra* note 71 at 779.

[74] *Ibid.*

[75] *Ibid.*

[76] *Ibid.*

[77] 236 S.C. 257, 113 S.E. 2d 790 (1960).

Justice Toal then cited *Fowler* v. *Woodward*,[81] for its interpretation of *Hall* as a precedent of the proposition that a viable fetus that is injured while still in the womb need not be born alive for another to maintain an action for its wrongful death. The Court in *Fowler* emphasized that *Hall* "rested on the concept of the viable fetus is a person vested with legal rights."[82]

Finally, Justice Toal cited *State* v. *Horne*,[83] which concerned the conviction of the defendant of voluntary manslaughter under South Carolina's murder statute[84] for stabbing his wife who was 9 months pregnant in the abdomen. A Cesarean section was performed to try to save the child but the child died while still in the womb. The defendant appealed his conviction on the grounds that South Carolina did not recognize the crime of feticide. In a unanimous decision of the Supreme Court of South Carolina denying the appeal, it was declared that it would be "grossly inconsistent ...to construe a viable fetus as a 'person' for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context."[85]

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[78] *Whitner, supra* note 71 at 780.

[79] *Ibid.*

[80] *Ibid.* at 779.

[81] 244 S.C. 608, 138 S.E. 2d 42 (1964).

[82] *Whitner, supra* note 71 at 780.

[83] 282 S.C. 444, S.E. 2d 703 (1984) [hereinafter *Horne*].

[84] S.C. Code Ann. s 16-33-10 (1976).

On the basis of these precedents, Justice Toal concluded that there was not a rational basis for finding that a viable fetus is not a "person" in the context of the present case. In fact, Justice Toal declared:[86]

> Indeed, it would be absurd to recognize the viable fetus as a person for purposes of homicide laws and wrongful death statutes but not for purposes of statutes proscribing child abuse.

Justice Toal then explained why the policies enunciated in the *Children's Code* also support the view that a viable fetus is a 'person' in the context of that statute:[87]

> It shall be the policy of this State to concentrate on the prevention of children's problems as the most important strategy which can be planned and implemented on behalf of children and their families.

In the context of this policy, Justice Toal noted that "the consequences of abuse or neglect which takes place after birth often pale in comparison to those resulting from abuse suffered by the viable fetus before birth."[88] In short, Justice Toal concluded that the prevention policy of the *Children's Code*, along with its broad application to all children who have need of services, supported the inference that the legislature intended to include viable fetuses within the scope of its protection.[89]

Justice Toal then examined and rejected several arguments raised by Whitner. The introduction of bills in the South Carolina General Assembly addressing the criminalization of substance abuse during pregnancy or mandatory treatment did not support the inference that the legislators did not consider that prior legislation had addressed the issue.[90] The legislature's subsequent acts "cast no light on the intent of the legislature which enacted the statute being construed."[91] The argument that the

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[85] *Horne, supra* note 83 at 705.

[86] *Whitner, supra* note 71 at 780.

[87] S.C. Code Ann. s 20-7-20(c) (1985).

[88] *Whitner, supra* note 71 at 780.

[89] *Ibid.* at 780-81.

[90] *Ibid.* at 781.

interpretation of the statute to include viable fetus could lead to absurd results not intended by the legislature could be made whether the child has been born or not. The Court was only required to consider the facts of this case and there can be no question in this case that Whitner clearly endangered the life, health, and comfort of her child. The fact that many other state courts have held that conduct before the birth of the child does not give rise to criminal prosecution under state child abuse/endangerment or drug distribution statutes was irrelevant as they were decided on entirely different bodies of case law from South Carolina.[92] Furthermore, the United States Supreme Court has repeatedly held that the states have a compelling interest in the life of a viable fetus.[93]

The argument that ambiguities, such as the term child in the *Children's Code*, in a criminal statute, must be resolved in favor of the defendant failed because in the opinion of the Majority of the Court, the term child was not ambiguous and therefore the rule of lenity did not apply.[94] The argument that Whitner had ineffective assistance from counsel failed because the *Children's Code* applied to an expectant mother's use of illegal drugs after her fetus is viable, and therefore it was not necessary for her lawyer to advise her that the statute under which she was prosecuted might not apply to prenatal drug use.[95] Whitner's claim that she lacked fair notice that her behavior constituted child endangerment failed because the plain meaning of child includes viable fetus, and because

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[91] *Ibid.*

[92] *Ibid.* at 782.

[93] In support of this proposition the Court cited: *Roe* v. *Wade*, 410 U.S. 113, 165, S. Ct. 705, 732-33, 35 L.Ed. 2d 147, 183-84 (1973) [hereinafter *Roe*]; *Planned Parenthood* v. *Casey*, 505 U.S. 833, 112 S.Ct. 2791, 120 L.Ed. 2d 674 (1992) [hereinafter *Planned Parenthood*]; *Webster* v. *Reproductive Health Servs.*, 492 U.S. 490, 109 S.Ct. 3040, 106 L.Ed. 2d 410 (1989).

[94] *Whitner, supra* note 71 at 784.

[95] *Ibid.* at 784.

it is common knowledge that the use of cocaine during pregnancy can harm the viable unborn child. Whitner therefore had all the notice the Constitution required.

The final argument raised by Whitner was that prosecuting her for using crack cocaine after her fetus attains viability unconstitutionally burdened her right of privacy, or, more specifically, her right to carry her pregnancy to term. This argument failed because of the State's legitimate and compelling interest in protecting the life and health of the viable fetus.[96] Justice Toal emphasized the validity of his conclusion that Whitner's right of privacy, or her right to carry the pregnancy to term, had not been violated by examining this argument from a practical perspective:[97]

> ...it strains belief for Whitner to argue that using crack cocaine during pregnancy is encompassed within the constitutionally recognized right to privacy. Use of crack cocaine is illegal, period. No one here argues that laws criminalizing the use of crack cocaine are themselves unconstitutional. If the State wishes to impose additional criminal penalties on pregnant women who engage in this already illegal conduct because of the effect the conduct has on the viable fetus, it may do so. We do not see how the fact of pregnancy elevates the use of crack cocaine to the lofty status of a fundamental right....The State's imposition of an additional penalty when a pregnant woman with a viable fetus engages in the already proscribed penalty behavior does not burden a woman's right to carry her pregnancy to term; rather, the additional penalty simply recognizes that a third party (the viable fetus or newborn child) is harmed by that behavior.

The question arises as to what are the potential implications in Canada of Justice Toal's decision which was upheld by the U.S. Supreme Court? At this point, there are no indications that Canada will follow the American efforts to criminalize prenatal substance abuse. However, many of the concepts raised in Justice Toal's decision are of particular interest in that they are similar to the arguments raised by Justice Major in his dissenting opinion in *DFG*. Both judges argued that the fetus holds certain rights and privileges. Both judges rejected the argument that the fetus has no separate being apart from its mother. Both judges emphasized that the consequences of abuse or neglect after birth often pale in comparison to the consequences of abuse or neglect suffered by the fetus prior to birth. Both judges emphasized that the state has a compelling interest in the life of the fetus. In short, the implications of the U.S. Supreme Court's decision to uphold Justice Toal's decision is significant because it was consistent with Justice Major's view of the legal status of the fetus in many respects. It follows that law reformers should critically evaluate Justice Toal's decision for its potential to contribute to Canadians perception of the maternal/fetal relationship. Furthermore, we cannot be sure that Canadian policy-makers will not be persuaded by the precedent established by the U.S. Supreme Court in *Whitner* in view of the ever increasing devastation caused by the ravages of addiction. It follows that those who prefer supportive intervention directed at both rehabilitation of pregnant addicts, and the prevention of life long damage to future members of our society, as opposed to punitive intervention, would be well advised to re-examine the potential value of mandatory treatment for prenatal substance abuse.

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[96] In support of this proposition the Court cited *Roe* and *Planned Parenthood, supra* note 93.

[97] *Whitner, supra* note 71 at 786.

Infrequently, mental health legislation has been relied upon as a basis for involuntary committal of pregnant women to protect the unborn child.[98] More commonly, child welfare legislation has been invoked to support apprehension either before or after birth.[99] The fundamental issue in these cases is whether the unborn child is a child in need of protection within the meaning of relevant provincial legislation. For example, in 1981, the Ontario Provincial Court held that the fetus was a "child in need of protection" and granted an order making the fetus a temporary ward of the Children's Aid Society.[100] Similarly, the British Columbia Supreme Court has declared that a pregnant woman's excessive alcohol and drug consumption constituted child abuse.[101] Recent cases however, provide a strong precedent for challenging this approach and support the view that judicial restraint must be exercised in such cases. For example, the landmark American decision in *Re A.C.*[102] held that a fetus was not a "child" for the purposes of apprehension under child welfare legislation.[103] Similarly, the Manitoba Court of Appeal in *DFG* concluded that mental health legislation could not be applied as a basis for civil commitment of Ms. G. because the trial judges finding that Ms. G. was incompetent and mentally disordered was not supported by evidence.[104]

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[98] *Re Children's Aid Society of the City of Belleville* (1987), 59 O.R. (2d) 204 (Ont. Prov. Ct.).

[99] *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249.

The trend of judicial restraint is also apparent with respect to the Court's use of its *parens patriae* jurisdiction to protect the unborn child from avoidable harm. For example, in a 1996 unreported decision, the New Brunswick Court of Queen's Bench held that the *parens patriae* jurisdiction does not extend to protection of the unborn child.[105] In *Re A*,[106] Justice Steinberg stated that he did not believe that the Court's *parens patriae* jurisdiction was broad enough to force the confinement of a pregnant woman to protect her unborn child. However, it was apparent that he was somewhat ambivalent about this decision as he also suggested that the jurisdiction may be available if exercised with extreme caution.[107]

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[100] *Supra* note 98.

[101] *Re Superintendent of Family and Child Service and McDonald* (1982), 135 D.L.R. (3d) 330 (B.C.S.C.).

[102] *Re A.C., supra* note 25.

[103] See also *G. (R.C.)* v. *Joseph Brant Memorial Hospital* (1987) 10 R.F.L. (3d) 379 (Ont. H.C.).

[104] *DFG, supra* note 8 at para. 12 cited to M.J. No. 398 (QL).

[105] *New Brunswick (Minister of Health and Community Services)* v. *Hickey*, N.B.Q.B. (Fam. Div.) November, 1996 [unreported]. This case was referred to in *DFG, supra* note 8 at para. 51.

[106] *Re A* (1990), 28 R.F.L. (3d) 288 (Ont. U.F.C.). This case was also referred to in

The Supreme Court of Canada's analysis of the *parens patriae* jurisdiction in the *DFG* case will be examined in detail in chapter three. Suffice for the purposes of this review to state that the Majority concluded that the jurisdiction was not available to protect the unborn child. However, in Justice Major's dissenting opinion, it was concluded that if exercised with extreme caution, the *parens patriae* jurisdiction should be available to protect the unborn child from substance abuse during pregnancy.

Finally, the question has arisen as to whether a pregnant women may be restrained from harming her unborn child by invoking tort law. Although there is some case precedent supporting the right of a child, once born, to sue his or her mother for prenatal injuries,[108] the proposition that an unborn child may sue his or her mother before birth was rejected by the Supreme Court of Canada in the *DFG* case. The Court stated, however, that if it could be predicted with some certainty that extending tort liability to the lifestyle choices of pregnant woman would diminish the problem of injured infants, a change in the law may be justified.[109]

DFG, supra note 8 at para. 51.

[107] *Ibid.* at 298.

[108] *Dobson (Litigation Guardian of)* v. *Dobson,* (1997) 148 D.L.R. (4th) 332 (N.B.C.A.); *Lynch* v. *Lynch,* (1991) 25 N.S.W.L.R. 411 (C.A.).

[109] *DFG, supra* note 8 at para. 43. The Courts examination of this issue will be examined in detail in chapter three.

Blank predicts that "the trend in the courts toward finding a cause of action against a pregnant woman for conduct injurious to her unborn child is bound to heighten"[110] as medical technology enhances our understanding of the harmful effects of certain maternal behaviors on fetal health. If this alleged trend continues, it may fuel the "maternal/fetal conflict" debate and promote the view of an adversarial relationship between mother and unborn child. This possibility reinforces the need to rethink the maternal/fetal relationship in circumstances of alleged "maternal/fetal conflict."

In conclusion, it is now widely accepted that reliance on legal mechanisms not specifically intended to address circumstances of alleged "maternal/fetal conflict" does not provide an optimal framework for legal intervention to prevent substance abuse during pregnancy. Specific legislation developed pursuant to a thorough law reform process is necessary. In so doing, the misconceptions of legal intervention during pregnancy arising from the inappropriate use of legal mechanisms not specifically intended to address circumstances of alleged "maternal/fetal conflict" must be identified and distinguished.

Child abuse statutes or mental health statutes are the two legislative models most often considered as providing a framework for the development of specific legislation directed at the prevention of substance abuse during pregnancy. Child protection legislation is considered a potential framework because children born with FAS/FAE or drug addiction arguably fall under the state child protective services. However, one of the problems with this framework is that "child protection law does not protect a parent's right to be free from civil commitment..."[111]

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[110] Blank, *supra* note 34 at 75.

[111] J. Wilton, "Compelled Hospitalization and Treatment During Pregnancy: Mental Health Statutes to Protect Children from Prenatal Drug and Alcohol Exposure" (1991)

Mental health legislation is a less obvious model for legislation designed to protect maternal and fetal health from the adverse effects of alcohol and drug abuse. Wilton is a proponent of this framework for reasons succinctly summarized as follows:[112]

> ...it does not perpetuate a perpetrator-victim view of alcoholism and addiction. Under mental health law, the state has an interest in protecting the patient as well as the community. In extending this model to maternal health legislation, the state's interest is in protecting maternal health as well as the health of the fetus... Mental health legislation is also a good model because it contains specific procedural safeguards against infringement of the constitutional right to bodily integrity. Among these are provisions such as the least restrictive alternative requirement and the requirement of a prior adversary hearing before involuntary hospitalization.
>
> Additionally, mental health law is an appropriate model because it traditionally provides for hospitalization for drug and alcohol addiction.

Although Wilton presents a valid perspective, the stigma associated with civil commitment under mental health law must not be overlooked. Furthermore, the level of procedural protection varies between jurisdictions and would therefore have to be individually evaluated. For example, the United States mental health legislation has a higher level of procedural protection against civil commitment than does the Canadian equivalent.

Many countries have provisions for the civil commitment of individuals suffering from substance abuse.[113] Brown noted that of the forty-three countries surveyed by Porter, fifteen provided for civil commitment of individuals with severe addiction problems under legislation specific to drug use. Eleven of those countries also mandated reporting

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XXV (2) Family Law Quarterly 149 at 168.

[112] *Ibid.*

[113] B. Brown, "Civil Commitment- An International Perspective" (1988) 18 (4) The Journal of Drug Issues 663.

of drug-dependent persons to state authorities.[114] However, Canada does not have legislation authorizing civil commitment for severe addiction.

A study of the use of civil commitment in the United States undertaken pursuant to a recommendation of the Bush Administration[115] concluded that "24 states and the District of Columbia have specific, detailed statutory provisions authorizing the involuntary civil commitment of drug-dependent persons either separate from, or joined with, provisions for the commitment of persons with mental illness, alcoholism, or developmental disabilities."[116] The following is a summary of the types of provisions contained in this legislation:[117]

> Modeled after mental health commitment laws, all state laws limit involuntary civil commitment to drug-dependent persons who are in need of treatment, are likely to be dangerous to themselves or others, or who are unable to meet their basic needs for sustennance, shelter or self-protection. Commitment proceedings may be initiated by any adult or, in emergencies, by law enforcemnt or authorized care or treatment providers. Respondents may be detained pending a formal judicial hearing for purposes of evaluation or emergency care and treatment. Most states permit treatment facilities to discharge respondents pending a judicial hearing. All require at least some procedural protections, including notice, right to counsel, judicial review, and a definite initial commitment period, varying from 30 days, mandated in several states, to a period 'not to exceed three years in Rhode Island.'

In conclusion, this study noted that:[118]

> ... the translation of involuntary civil commitment laws into viable programs and fair and workable practices is fraught with diffculties. It would be foolhardy to assume that in most jurisdicitions 'the law on the books' bears a close relationsip to the 'law in practice.' Changes in one may not be reflected in changes in the other.

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[114] *Ibid.* at 666.

[115] The White House, *National Drug Control Strategy* 42-43 (September 1989).

[116] S. Anderson Garcia and I. Keilitz, "Involuntary Commitment of Drug Dependent Persons With Special Reference to Pregnant Women" (1991) 15 (4) Mental and Physical Disability Law Reporter 418 at 419.

[117] *Ibid.*

[118] *Ibid.* at 423.

There are only two States with pregnancy specific legislation providing for civil commitment for severe drug addicition. In 1989, Minnesota passed comprehensive legislation to "facilitate the early identification of and voluntary services to drug abusing pregnant women."[119] The mandatory reporting provisions of this legislation requires mandatory reporters to immediately report to the local welfare agency if the person knows or has reason to believe that a pregnant women has used a controlled substance for nonmedical purposes.[120] Upon filing of the report, the welfare agency it is required to:[121]

> Immediately conduct an assessment and offer services inicated under the circumstances. Services offered may include, but are not limited to, a referral for chemical dependency assessment, a referral for chemcial dependency treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action... including seeking an emergency admission...The local welfare agency shall seek an emergency admission...if the pregnant woman refuses recommended voluntary services or fails recommended treatment.
>
> Civil commitment is an option only if the mother's behavior is:[122]
>
> (a) manifested by instances of grossly disturbed behavior or faulty perceptions; and (b) poses a substantial likelihood of...harm to self or others as demonstrated by: (i) a failure to obtain ...food, clothes, shelter or medical care... or (ii) an attempt or threat ... of harm to self or others...

Minnesota's statutory program has described as a comprehensive approach to the prenatal substance abuse that should serve as a model for other jurisdictions because it conceptualiz[es] the maternalfetal relationship as an interdependent one and addresses the problem on a multidiciplinary level.[123]

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[119] M. Lencewicz, "Don't Crack The Cradle: Minnesota's Effective Solution For The Prevention of Prenatal Substance Abuse -- Analysis of Minnesota Statute Section 626.5561" (1994) 63 Rev. Jur. U.P.R. 599 [hereinafter *Minnesota's Answer*].

[120] Minn. Stat. Ann. § 626.5561 (West 1989). The term "controlled substances" refers only to the cocaine, heroin, phencyclidine, methamphetamine, or amphetamine. Minn. Stat. Ann. § 235B.02, subd. 2 (West Supp. 1993).

[121] Minn. Stat. Ann. § 626.5561, subd. 2 (West Supp. 1992).

[122] Minn. Stat. Ann. § 235B.02, subd. 13 (West 1989).

South Dakota recently enacted amendments to its legislation concerning involunarty commitment for alcohol or drug abuse. Effective July 1, 1998, this legislation now provides for the involuntary commitment of pregnant substance abusing women for alcohol or drug treatment.[124] This is the only legislation in the United States providing for civil commitment for alcohol abuse during pregnancy. One of the senator's who co-sponsored this legislation commented that there is "no guarantee that it will help that particular child, but we hope it will help the second, third and fourth babies in a family..."[125] The other senator who co-sponsored this legislation said that the legislation was passed because fetal alcohol syndrome "has become an epidemic."[126]

VI. HIGHLY POLARIZED POSITIONS CONCERNING THE APPROPRIATE RESPONSE

Circumstances of alleged "maternal/fetal conflict" have provoked highly polarized positions concerning the appropriate response. At one extreme, the legislature and the Courts are urged to advance women's right to reproductive autonomy and freedom of choice. In so doing, they are asked to declare that the fetus has no legal rights. At the other extreme, there are those who believe that an unborn child must be granted the legal status of a "person" from the time of conception. The unborn child has a right to be born healthy. The rights of the unborn must take priority over the rights of pregnant women.

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[123] *Minnesota's Answer, supra* note 119.

[124] S.D. Codified Laws § 34-20A-63 (Michie: 1996 & Supp. 1998); and S.D. Codified Laws § 34-20A-70 (Michie: 1996 & Supp. 1998).

[125] "S. Dakota to enforce treatment of pregnant moms who drink" [cnn.com/HEALTH/9805/24/fetal.syndrome/index.html].

[126] *Ibid.*

The following overview of these widely divergent positions illustrates the counterproductive implications of an adversarial approach to the maternal/fetal relationship.

The authorities relied on to describe each of these positions have been carefully selected because of their relevance to other chapters of this thesis. Professor Overall is a leading proponent of women's right to reproductive autonomy[127] and was a prominent resource to the Commission.[128] Sanda Rodgers also contributed a major study to the Commission concerning judicial intervention during pregnancy.[129] Dr. Keyserlingk is recognized as a leading advocate of the rights of the unborn child.[130]

From Professor Overall's perspective, fetal rights advocates "lose sight of the fact the issue at stake is the bodily integrity and autonomy of women."[131] She suggests that the issue of fetal rights must be considered in light of the question "Whose body is it anyway?"[132] Professor Overall's answer to this question is consistent with her view that fetal rights advocates claim "squatters rights for the fetus" to a woman's uterus: [133]

> A woman's body does not belong to the state; it does not belong to physicians; it does not belong to the woman's husband, partner, or the father of her children, and, most important, it does not belong to the fetus.

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[127] For example see C. Overall, "Feminism, ontology, and 'other minds'" in L. Code, S. Mullett & C. Overall. eds., *Feminist Perspectives: Philosophical Essays on Method and Morals,* (Toronto: Canadian Cataloguing in Publication Data, 1988) 89.

[128] Report, *supra* note 42.

[129] Rodgers, *supra* note 26.

[130] E. Keyserlingk, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective* (Montreal: Quebec Research Centre of Private and Comparative Law, 1984).

[131] Christine Overall, "Mother/Fetus/State Conflicts" (1989) 9 Health Law in Canada 101 [hereinafter "Conflicts"].

[132] *Ibid.*

[133] *Ibid.* See also C. Overall, "Pluck a Fetus from Its Womb: A Critique of Current Attitudes Toward the Embryo/Fetus" (1986) 24 West. Ont. L. Rev. 1.

To Professor Overall, granting the fetus an advocate "is a large and dangerous step towards denying the autonomy of pregnant women."[134] To allow others to represent the fetus and "insist on fetal surgery or block an abortion is to hand over control of the woman's body to the physician or spouse."[135] Professor Overall argues that if pregnant women are to have the same freedom of ownership of their bodies as accorded to every member of our culture, "the locus of responsibility for deciding what happens in and to her body rests with her."[136] She argues that the rejection of claims about the alleged rights of the fetus to take priority over a pregnant woman's right to control her body has to do with the odiousness of slavery.[137] Professor Overall recommends that rather than limiting a women's right to reproductive autonomy and freedom of choice, policy makers must address why intervention may seem necessary.[138]

Proponents of women's rights to reproductive autonomy argue that legislative and judicial responses to social problems, including substance abuse during pregnancy, have proven to be counterproductive.[139] This arguement however, is debateable. As noted by the majority of the Supreme Court of Canada in the *DFG* case:[140]

> No clear consensus emerges from the debate on the question of whether ordering women into "places of safety" and mandating treatment provide the best solution or, on the contrary, create additional problems.

This posistion is consistent with a 1995 research paper on mandated and coerced treatment for substance abuse prepared by the Addiction Research Foundation which concluded that "policy-orientated arguments about the effectiveness or harm of mandated and coerced treatment do not rest on a solid empirical foundation."[141] This same research also concluded that:[142]

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[134] *Ibid.*

[135] *Ibid.*

[136] *Ibid.*

[137] *Ibid.*

[138] *Ibid.*

[139] Rodgers, *supra* note 26 at 94.

[140] *DFG, supra* note 8 at para. 43.

> Mandated and coerced treatment for alcohol and other drug problems may potentially provide a cost-effective, rehabilitative solution to the social costs of offenses and recidivism committed by offenders with alcohol and drug problems...
>
> In lieu of systematic scholarship on the impact of mandated and coerced treatment for substance abuse, it would be irresponsible for the ARF [Addiction Research Foundation] to adopt a position either for or against diversion-to-treatment initiatives at this time.

And for good reason. "...the fact remains that many addicts do not enter the treatment system unless they are forced to do so."[143] Indeed, involuntary commitment of mentally disordered persons, including individuals suffering from substance abuse during pregnancy, "has been the subject of increasing litigation and legislative activity during the last decade."[144]

Secondly, the fact is that society does rely on legislative and judicial responses to social problems such as severe mental illness and child abuse. What evidence is there to establish that mental health legislation, utilized to commit people suffering from severe mental illness, is not counterproductive by encouraging people with serious mental illness to avoid medical care? Similarly, what evidence is there to establish that child abuse legislation would be effective as opposed to counter-productive by causing incompetent or abusive parents fearing apprehension of their children to avoid help?

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[141] Mandated Treatment and Coercion Working Group, by C. Wild et. al., Social Evaluation and Research Department, Addiction Research Foundation, *Mandated and Coerced Treatment for Substance Abuse: Current Knowledge and Future Research Directions* (Toronto: Addiction Research Foundation of Ontario, 1995).

[142] *Ibid.*

[143] J. Platt et. al., "The Prospects and Limitations of Compulsory Treatment For Drug Addiction" (1988) 18 (4) The Journal of Drug Issues 505 at 511.

[144] C. Stromberg and A. Stone, " A Model State Law on Civil Commitment of the Mentally Ill" (1983) 20 Harv. J. Legisl. 275. Please refer to pages 40-41 of this chapter for a further discussion of legislative activity concerning involuntary commitment for alcohol and drug abuse treatment.

The author supports Blank's view that while programs to provide adequate care to pregnant women should be the priority, this approach may not be effective for a minority of pregnant women whose behavior is exposing the unborn child to a significant risk of harm:[145]

> Even the most comprehensive and effective prenatal health program, however, will not resolve problems with a minority of pregnant women who are either unable or unwilling to alter their behavior that poses a risk of harm to the unborn. Chronic alcohol abusers, drug addicts and others whose actions are indisputably harmful to the developing fetus, and who are unresponsive to preventive efforts, might justly be precluded from enjoying the rights of parenthood or legally required to take responsibility for the consequences of their behavior, but only after society has better met its responsibilities in averting such behaviors. Policy guidelines are needed that encourage healthy maternal behavior, but also protect against unwarranted state intrusion into the procreative choice of women. This is a very difficult, although critical, balance to achieve.

Proponents of the rights of the unborn child argue that the state's interest in protecting the health of future members of society takes precedence over women's rights to reproductive autonomy and freedom of choice. Dr. Keyserlingk[146] argued, in his 1984 thesis, that:[147]

> ...we, in Canada and elsewhere, must begin to formulate more explicitly and coherently than we have to date, those "special safeguards" and "legal protections" for the unborn urged by the United Nations General Assembly some twenty-two years ago. More specifically (and more modestly) the

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[145] Blank, *supra* note 34 at 76.

[146] At the time of writing on this issue, Dr. Keyserlingk was the Coordinator of the Protection of Life Project of the Law Reform Commission of Canada. He also taught in the Faculty of Law, McGill University. He specifically stated that his work did not necessarily reflect the views of the Commission.

[147] E. Keyserlingk, "The Unborn Child's Right to Prenatal Care" (Part I; Part II), Health Law in Canada 3 (1982): 10-21; 31-41 at 10 [hereinafter Keyserlingk].

> paper proposes and explores from a comparative law perspective both a particular right, namely a right of the conceived but unborn to prenatal care, and appropriate legal safeguards and protections for that right.

The "special safeguards" and "legal protections" referred to by Dr. Keyserlingk are from the preamble of the Declaration of the Rights of the Child which he quoted at the commencement of his article:[148]

> The Child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

This quote was also referred to by the Manitoba Court of Appeal and the Supreme Court of Canada in the *DFG* case.

Dr. Keyserlingk's position concerning the need to provide legal protection for the unborn child from substance abuse during pregnancy may be summarized as follows:[149]

> ... the unborn child's right to prenatal care, though not absolute, should not have to give way to maternal rights, interests, wishes or habits other than and lesser than her life or health. For example there should be no contest at all between a mother's desire to smoke, drink or consume drugs excessively, and the unborn's right to be (legally) protected against the serious risk of resulting disability to it.

Dr. Keyserlingk's position has been widely criticized by proponents of woman's rights to reproductive autonomy. One commentator described the chief complaint as being that Dr. Keyserlingk "stereotypically and improperly" treats women as "nothing more than fetal 'incubators' or simply as a means to an end."[150] Along a similar line, Watters described Dr. Keyserlingk's proposal's for "court ordered protective mechanisms" as presenting "a number of Orwellian nightmares."[151] Watter's concluded his critique of

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[148] The preamble to the Declaration of the Rights of the Child (U.N. Document A/4354 (1959)).

[149] Keyserlingk, *supra* note 147.

[150] S. Martin & M. Coleman, "Judicial Intervention in Pregnancy (1996) 47 McGill L. J. 951 at 952.

[151] W. Watters et. al. "Response to Edward W. Keyserlingk's Article: The Unborn Child's Right to Prenatal Care" (1983-85) 4-5 Health Law in Canada 32.

Dr. Keyserlingk's work on a constructive note:[152]

> Mr. Keyserlingk has done a considerable service in bringing the issue of proper antenatal care to the foreground. However, this is an issue which cannot be considered in isolation. It must be seen in the context of the current status of sexual enlightenment, freedom of choice around reproduction and the decision making around parenting. To assume otherwise is inexcusably naive. We can only hope that this will stimulate both health care professionals and legal scholars to re-examine in depth the many complex issues involved.

Dr. Keyserlingk himself acknowledged that his work concerning the unborn child's right to prenatal care was his "first voyage into these somewhat stormy and relatively uncharted waters."[153] He acknowledged that "the perspective adopted here is more that of a 'wide angle' lens than a 'microscopic' lens." [154] Watter's suggestion that Dr. Keyserlingk's work may "stimulate health care professionals and legal scholars to re-examine in depth the complex issues involved"[155] is consistent with Dr. Keyserlingk's stated objective:[156]

> Hopefully the level of generality and the sweeping conclusions in some of what follows will not lead the reader to conclude that the lens used was not only wide angled but distorted. Many points, both those raised herein and other inadvertently overlooked, will be examined (and re-examined) in greater detail by this writer in subsequent studies, and hopefully by many others as well.

The criticism of Dr. Keyserlink's work has focused on the misconception that he is primarily concerned with "fetal rights." In fact, the focus of his concern is actually the prevention of risks during gestation that will jeopardize the health and well-being of the inevitable personhood of the fetus as a future member of our society. Concern for the well-being of the child when born has the potential to promote the well-being of women and society generally if properly developed pursuant to a thorough process of law reform. This is particularly true in the case of substance abuse during pregnancy. "Serious and sustained political discussion"[157] of the complex issues associated with women's substance addiction problems, including mandatory treatment for prenatal substance abuse, can only enhance women's opportunity to overcome the oppression of addiction.

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[152] *Ibid.* at 34.

[153] Keyserlingk, *supra* note 147 at 10.

[154] *Ibid.*

[155] *Ibid.* at 34.

[156] *Ibid.* at 40.

Blank succinctly articulated the need to focus on the promotion of the birth of healthy children as opposed to "fetal rights":[158]

> ...the term "fetal right" is a distortion of the real issue and obscures what ought to be the primary concern - the health of the child when born. It is not the fetus that has rights; rather, it is the child once born that must be protected from avertable harm during gestation. The goal of any policies designed to make the fetal environment as safe as possible should be to maximize the birth of healthy children. The unfortunate, but conscious focus on fetal rights, instead of the rights of the newborn, intensifies opposition without contributing to resolution of the problem.

VII. QUESTIONING THE RIGHTS APPROACH TO THE MATERNAL/FETAL RELATIONSHIP

Circumstances of alleged "maternal/fetal conflict" have raised two critical questions concerning the need to balance the rights of pregnant women relative to the rights of unborn child. Should the Courts or the legislatures balance the interests of the fetus (or the interests of the state in protecting the fetus) with the interests of the mother? If so, how should the balancing of interests be accomplished?[159] These critical questions have provoked highly polarized responses reflecting the predominant adversarial view of the maternal/fetal relationship resulting from "rights talk" and "the legacy of the abortion debate." These responses have impeded effective analysis of potential intervention to prevent substance abuse during pregnancy such as mandatory treatment for prenatal substance abuse.

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[157] *Rights Talk, supra* note 3 at x.

[158] Blank, *supra* note 34 at 87.

[159] *Bioethics, supra* note 26 at 154.

Harvard Law Professor Mary Ann Glendon, in her book entitled "Rights Talk: The Impoverishment of American Politics"[160] argues that "a certain kind of rights talk in our political discussions is both a symptom of, and contributing factor, to this disorder in the body politic."[161] This political disorder resulting from the "intemperate rhetoric of personal liberty"[162] is the corrosion of "personal responsibility and of civic obligation"[163] which, in Professor Glendon's view, are "the foundations on which individual freedom and security ultimately rest." [164]

Professor Glendon's work traces the evolution of a distinctive rights dialect and illustrates that it "frequently works against the conditions required for the pursuit of dignified living by free women and men."[165] Perhaps the fundamental problem identified by Professor Glendon is that the current rights discourse obstructs "serious and sustained political discussion."[166] It has, therefore, become increasingly difficult to define, debate and resolve critical issues. Throughout her book, Professor Glendon illustrates how the American rights dialogue is set apart from rights discourse in other liberal democracies by its:[167]

> starkness and simplicity, its prodigality in bestowing the rights label, its

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[160] *Rights Talk, supra* note 3.

[161] *Ibid.* at x.

[162] *Ibid.*

[163] *Ibid.*

[164] *Ibid.*

[165] *Ibid.*

[166] *Ibid.*

[167] *Ibid.*

> legalistic character, its exaggerated absoluteness, its hyperindivdualism, its insularity, and its silence with respect to personal, civic, and collective responsibilities.

Professor Glendon's brief development of these concepts in the introduction to her book is particularly thought provoking with respect to this thesis:[168]

> This unique brand of rights talk often operates at cross-purposes with our venerable rights tradition. It fits perfectly within the ten-second formats currently preferred by the news media, but severely constricts opportunities for the sort of ongoing dialogue upon which a regime of ordered liberty ultimately depends...A tendency to frame nearly every social controversy in terms of a clash of rights (a woman's right to her own body vs. a fetus's right to life) impedes compromise, mutual understanding, and the discovery of common ground. A penchant for absolute formulations...promotes unrealistic expectations and ignores both social costs and the rights of others. A near-aphasia concerning responsibilities makes it seem legitimate to accept the benefits of living in a democratic social welfare republic without assuming the corresponding personal and civic obligations.

The down side of "rights talk" examined by Professor Glendon is indeed reflected in the debate concerning the appropriate legal response to substance abuse during pregnancy. Rights talk has had the ironic result of creating adversaries out of pregnant women and their unborn children - the very relationship that is fundamental to the continued existence of human kind. The possibility of a mutually beneficial common interest in this relationship has been undervalued. The appropriate role of responsibility; mother to fetus, and state to mother and fetus and children, has not been adequately addressed. Politically motivated slogans have become the norm. Overall, the debate is often boiled down to an all-or-nothing contest between "women's rights" versus "fetal rights." The result is that while the debate has raged for decades, little has been accomplished to promote the best interests of women suffering from addiction and unborn children suffering from substance abuse during pregnancy.

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[168] *Ibid.* at xi.

Professor King has also criticized the rights framework in the context of substance abuse during pregnancy. She noted that complex social problems are typically analyzed with a balancing of rights framework. The problems are framed "in terms of sensible accommodation between rights-based liberalism and choice, on the one hand, and communitarianism, which stresses group interests on the other."[169] However, Professor King argues that a rights-based framework "is not useful to a discussion of women's substance abuse because it does not adequately account for the significance of procreative and caregiving roles."[170] She argues that a libertarian focus on individual autonomy and choice "fails to capture important features of a women's drug use, such as the harm it may bring"[171] to others arising out of her procreative and caretaking roles. In preference to a libertarian focus, Professor King recommends that policy makers focus on the interdependency of mother and fetus, and parent and child:[172]

> A more compelling analytical structure for developing drug policies for women would make different assumptions about the nature of the relationship that exists between mother and fetus, parent and child. This approach would assume that humans do not exist in self-interested isolation from others. In particular, we rely on parents to make decisions that will be in the best interest of their offspring. Much of this belief stems from our personal knowledge of the nature of interactions in intimate interpersonal relationships, such as those that exist between parents and children. The reality of family life and the sacrifice and attention to important others that it demands are not easily reconciled with a philosophy that judges human activities to be driven solely by self-interest.

Despite the shortcomings of rights-based strategies, Professor King observed that "many individuals, particularly women, are reluctant to move away from arguments about the maternal/fetal relationship that rest on autonomy and rights-based strategies."[173] This is because rights-based strategies "were the means that women successfully employed to free themselves"[174] from the oppression that was reflected in the traditional roles and responsibilities assigned to women based on the assumption that women have obligations to their fetuses. For example, the abortion debate was framed in terms of "women's rights to choose to terminate her pregnancy versus the fetus's right to live."[175] In result, the debate "pitted woman against fetus and assumed that their relationship was inherently adversarial in nature."[176] This adversarial understanding of pregnancy and the maternal/fetal relationship is described by Professor King as the "legacy of the abortion debate."[177]

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[169] *Helping Women, supra* note 1 at 595.

[170] *Ibid.* at 596.

[171] *Ibid.*

[172] *Ibid.* at 598.

Professor King concluded that using a conceptual framework based on an adversarial understanding of pregnancy overburdens and isolates women by holding them solely responsible for the pregnancy outcome. Arguments framed in terms of noninterference from others allows "men and the state to ignore responsibilities to women, fetuses and children."[178] Professor Glendon came to a similar conclusion based upon an examination of the results of utilizing a rights based strategy to resolve issues related to the abortion debate.

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[173] *Ibid.* at 604.

[174] *Ibid.*

[175] *Ibid.*

[176] *Ibid.*

[177] *Ibid.* This description raises the important consideration that although "maternal/fetal conflict" is distinguishable from abortion in that the child will be born, the abortion debate provides valuable insight into societies perception of the maternal/fetal relationship.

[178] *Ibid.* at 605.

Consistent with her view that we must "give ourselves the benefit of considering how other liberal pluralistic democracies approach the many vexing legal problems we have in common,"[179] Professor Glendon performed a comparative analysis of the outcome of similar challenges to abortion law reform between West Germany and the United States. She concluded that the American approach of making abortion a woman's prerogative made it easier to treat pregnancy, childbearing and childrearing as her responsibility:[180]

> Extending the right to be let alone to abortion makes it seem legitimate, not only for taxpayers but also for the fathers of unborn children, to leave the freely choosing right-bearer alone. It is no wonder the right is still so 'highly valued by civilized men.'

In reaching this conclusion, Professor Glendon described a case that reached the West German Constitutional Court in 1975.[181] This case challenged the validity of the statute regulating abortion and has been described as a "mirror image of *Roe* v. *Wade* in the sense that the statute in question was new and permissive, rather than archaic and restrictive."[182] The German legislation, which permitted elective abortions in the first trimester of pregnancy, was challenged on the ground that it violated the right to life of the fetus. The West German Constitutional Court "declined to rest its decision [on the abortion issue] either on the right to life claimed for the fetus or on the woman's personal liberty rights."[183] Rather, the Court decided that "the legislature must accord priority to human dignity."[184] In so doing, the Court concluded that the "legislature had violated the command to respect and protect human dignity when it permitted abortion on demand. The absence of any legal disapproval "gave the impression that abortion was no longer to be disapproved even from an ethical point of view."[185]

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[179] *Rights Talk, supra* note 3 at 146.

[180] *Ibid.* at 66.

[181] Judgment of Feb. 25, 1975, 39 BVerfG E 1. English translations: *The Abortion Decision of February 25, 1975, of the Federal Constitutional Court, Federal Republic of Germany,* Edmund C. Jann trans. (Washington, D.C.: Library of Congress, 1975); "West German Abortion Decision: A Contrast to *Roe* v. *Wade,"* Robert E. Jonas and John D. Gorby, trans., (1976) 9 John Marshall Journal of Practice and Procedure 605.

[182] *Ibid.* at 63.

[183] *Ibid*

The West German Constitutional Court then went on to state that according priority to human dignity does not mean that important interests of women can be ignored; "[n]or does it mean that criminal punishment has to be the principle technique employed to carry out the duty of protecting life."[186] Indeed the Court recommended that "educational efforts and social assistance to pregnant women should be foremost among the means used to protect developing life."[187]

In result, the West German legislature enacted a compromise statute "making early abortions relatively easy to obtain, and imposing more safeguards for the fetus as the pregnancy nears term."[188] However, the statute also included a process directed at the protection of human dignity. Professor Glendon succinctly summarized that process as follows:[189]

> ...she is provided with counselling where she is advised of the benefits and services available to her, especially those that would facilitate continuation of the pregnancy. These services include medical care in pregnancy and childbirth and generous social assistance to single mothers, as well as a highly efficient system of imposition and collection of child support. Except in an emergency, she must then observe a three day waiting period. If, after informed reflection, the woman still wishes to terminate her pregnancy, she obtains a document from a doctor stating "whether" her pregnancy poses a serious danger to her physical or mental

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[184] *Ibid.*

[185] *Ibid.*

[186] *Ibid.* at 64.

[187] *Ibid.*

[188] *Ibid.* at 65.

[189] *Ibid.*

> health - a danger that cannot be averted by any other means she can reasonably be expected to bear. Since this documentary requirement does not give the doctor a veto over the woman's decision (it is only an opinion on *whether* she is subject to serious hardship), the step is best understood as one more procedure required in view of the gravity of the decision. With the doctor's certificate, the woman can obtain an abortion within the national health insurance system.

Professor Glendon compared the effect of the West German Statute which focused on the protection of human dignity with that adopted by the United States which was developed out of the all-or-nothing contest between the right to life of the fetus against the pregnant woman's right to privacy and self determination:[190]

> In the United States today, by contrast, poor pregnant women....have their constitutional right to privacy and little else. Meager social support for maternity and child-raising, and the absence of public funding for abortions in many jurisdictions, do in fact leave such women largely isolated in their privacy. Justice Blackmun's assertion that privacy protects a woman's relationship with her doctor has an especially hollow ring now that most abortions are performed in high-turnover clinics where the woman does not even meet "her" doctor until she is already on the table. As for other potential sources of support and help, the Supreme Court has struck down requirements that pregnant women even be informed of them saying such laws impermissibly "wedge" the state's message favoring childbirth into the woman's sphere of privacy.

The primary lesson from Professor Glendon's comparative analysis is that Canada must refrain from using a rights-based framework to resolve issues concerning the maternal/fetal relationship. Canadian policy makers will serve women, children and society generally by focusing the protection and promotion of human dignity rather than the contest involving "women's rights" versus "fetal rights." This entails understanding the materal/fetal relationship as an interactive unit. As stated by Professor King:[191]

> For effective family policy, including drug policy for women, we need to understand terms such as duty, responsibility, and obligation in ways that do not presume that the individuals in a relationship act primarily in self-interested ways. We also need to take special note that individuals

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[190] *Ibid.*

[191] *Helping Women, supra* note 1 at 615.

> in many intimate relationships do not have equal power in those relationships. Understanding the maternal-fetal relationship as an intimate interactive unit, in which there is a severe discrepancy in power, better helps us define the nature of the moral relationship that exists between the pregnant woman and the fetus. Using this redefinition of the maternal-fetal relationship offers drug policy makers a more realistic and morally supportable basis for developing drug policy for women.

Unfortunately, the balancing of rights approach to circumstances of alleged "maternal/fetal conflict" continues to be promoted by legal commentators. For example, a case comment on *DFG,* recommending that the Supreme Court of Canada affirm the decision of the Manitoba Court of Appeal, concluded that the most serious implication of judicial intervention to control substance abuse during pregnancy is that it would detrimentally alter "the existing balance of rights in Canadian law between the woman as a human being entitled to full legal rights of personhood and the fetus as a non-person entitled to no such rights."[192] Indeed, the balancing of rights approach to substance abuse during pregnancy was also condoned in the *DFG* case. In this regard, the Manitoba Court of Appeal declared:[193]

> An extension of child protection law to those yet unborn involves moral choices and a balancing of a mother's rights against those of her future child. The making of those choices and the delicate balancing would more appropriately be undertaken by a body directly answerable to society...

Similarly, the majority of the Supreme Court of Canada declared:[194]

> If anything is to be done, the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women.

The result of the "rights talk" approach is that it forced the abortion debate "into a seemingly nonnegotiable deadlock between the fetus's 'right to life' and the pregnant woman's 'right to choose.'"[195] A similar nonnegotiable deadlock between other fetal rights, such as the right not to be abused by drug exposure, versus woman's right to freedom of choice and reproductive autonomy can also be expected if a rights based approach is pursued.

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[192] Case Comment *DFG, supra* note 32 at 330.

[193] *DFG, supra* note 8 at para. 34 cited to M.J. No. 386 (QL).

[194] *Ibid.* at para. 56 cited to S.C.J. No. 96 (QL).

VIII. CONCLUSION

The conceptual shift from a rights-based framework to a view of the maternal-fetal relationship as an interactive unit will be a challenging one. Fundamental to this shift is the need to re-examine commonly held misconceptions concerning circumstances of alleged "maternal/fetal conflict." Substance abuse during pregnancy must be distinguished from circumstances involving an actual conflict such as some cases of enforced Cesareans and *intra-utero* surgeries. The slippery slope argument must be carefully assessed so as not to become an "*in terrorem* argument and lose whatever value it may legitimately possess."[196] Legal intervention to prevent substance abuse during pregnancy in extreme and narrowly defined circumstances is not a precedent for society to control every action of pregnant women including the decision of whether or not to have an abortion. The overly used argument that legal intervention to prevent substance abuse during pregnancy may do more harm than good must be addressed on the basis that this possibility has not been supported by empirical research. Indeed, the Addiction Research Foundation has concluded that it would be irresponsible for policy makers to make decisions on the basis of this possibility. Similarly, it must be acknowledged that women abusing substances during pregnancy are not exercising freedom of choice but rather are responding to "the ravages of addiction."[197]

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[195] *Rights Talk, supra* note 3 at 66.

[196] *DFG, supra* note 8 at para. 127.

How should we protect and promote human dignity in the context of substance abuse during pregnancy? The fact that FAS is the leading cause of preventable birth defects in North America, and that children born suffering from substance abuse during pregnancy is epidemic, raises questions concerning the adequacy of responses based solely on voluntary treatment. Indeed, the tragic circumstances of Ms. G. and her first two children permanently disabled by substance abuse during pregnancy and permanent wards of the state raises questions as to whether pregnant women severely addicted to substances have the capacity to voluntarily participate in drug rehabilitation programs in a timely manner.

DFG has directed that Parliament, and not the Courts, must address the question of the appropriate legal response to substance abuse during pregnancy. The "legacy of the abortion debate," and resulting adversarial view of the maternal-fetal relationship suggests that Parliament should avoid a rights-based framework when addressing the issue so as to avoid the "nonnegotiable deadlock" between the rights of pregnant women and the rights of the unborn child that continues to paralyze the raging abortion debates. Although their positions appear absolutely opposed, both advocates of fetal rights and women rights assert that their positions are to protect and enhance the sanctity of human dignity. It follows that Canadian policy-makers will serve women, fetuses and children well by focusing the protection and promotion of human dignity rather than the contest between "women's rights" versus "fetal rights." This will require an evaluation pursuant to a thorough process of law reform of the potential of civil commitment of drug dependent pregnant women to prevent substance abuse during pregnancy.

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[197] *Ibid.* at para. 5.

It is arguable the proposals for mandatory treatment for drug dependent pregnant women are "unlikely to be workable because, despite the rhetoric over society's concern for fetal health, the resources needed to adequately implement it are unlikely to be forthcoming."[198] However, if policy-makers focus on the long-term rather than the immediate, examination of proposals for mandatory treatment for prenatal substance abuse are clearly indicated. A study of the American Medical Association pointed out that caring for drug exposed newborns adds more than $500 million a year to the national total of normal infant health care costs. This study also indicated that effective treatment programs could yield savings within their first year of operation.[199] From a more general perspective, the Addiction research Foundation of Ontario estimated annual the cost of alcohol abuse in Canada to be $11.6 billion.[200] In preference to this pessimistic view based on inadequate resources, the author adopts Professor Glendon's view that "politics...is also an art - the art of the impossible-and we spurn its transformative dimension at our peril."[201]

In short, law reform initiatives directed at the prevention of substance abuse during pregnancy must focus on the fact that "the rights of parents, affected offspring, and society in most instances will be congruent: all parties benefit by the birth of healthy children and must work towards that goal."[202] Canadian policy makers will serve women, fetuses and children well by focusing the protection and promotion of human dignity rather than as a contest between women's rights versus fetal rights. This can only be accomplished if law reformers replace our current rights talk with political discourse focused on an "ongoing dialogue between freedom and responsibility, individualism and community, [and] present needs and future plans..."[203] We must remove "that blind spot [that] seems to float across our political vision where the communal and social, as distinct from individual or strictly economic dimensions of a problem are concerned."[204] In so doing, we must examine the need to nurture and utilize "the seedbeds of civic virtue"[205] such as the family, religious communities and other primary groups such as aboriginal communities. The addiction problems that are ravaging our country, including substance abuse during pregnancy, are fundamentally connected to complex social problems within its seedbeds. It may sound trite to declare that these problems will not be resolved by standing one right against another; women against the fetus or society against women. However, the ongoing rhetoric of "maternal/fetal conflict" is a clear indication that this critical concept is still challenged and often rejected by major stakeholders in the debate. The challenge of refining the rhetoric of rights, and its influence on the maternal/fetal relationship, seems overwhelming. On this issue, Professor Glendon acknowledges that "the current state of the art [of politics] does not exactly provide grounds for optimism..."[206] However, she does not view the issue as hopeless. Rather, she ultimately concludes that there is still room within the art of politics "for the more sober, responsible attitude that prophets have called hope."[207] It is the author's hope that in this chapter, and throughout the thesis, it becomes evident that there are sound reasons for critically examining the potential of mandatory treatment for prenatal substance abuse to promote "maternal/fetal welfare."

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[198] R. Blank, "Mandating Outpatient Treatment for Pregnant Substance Abusers: Attractive but Unfeasible" (1996) 15 (1) Politics and Life Sciences 49.

[199] S. Sanduski, "Policy Development for Women and Children's Drug Treatment Services" in P. Vamos & P. Corriveau, eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 420 at 421.

[200] J. LeCavalier, "Canada's Drug Strategy: Rising to the Challenge" in P. Vamos and P. Corriveau, eds., *Drugs and Society to the Year 2000* (Ottawa: The Portage Program for Drug Dependencies Inc., 1992) 96 at 99.

[201] *Rights Talk, supra* note 3 at xii.

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[202] Blank, *supra* note 32 at 79.

[203] *Rights Talk, supra* note 3 at xii.

[204] *Ibid.* at 112.

[205] *Ibid.* at xii.

[206] *Ibid.* at 183.

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[207] *Ibid.*

CHAPTER THREE
THE LANDMARK CASE CONCERNING SUBSTANCE ABUSE DURING PREGNANCY

> It is not every evil which attracts court action; some evils remain for the legislature to correct.[1]
>
> Justice McLachlin, Supreme Court of Canada

I. INTRODUCTION

The controversial and highly publicized decision in *Winnipeg Child and Family Services v. G. (D.F.)*[2] raises the challenging issue of whether mandatory treatment for prenatal substance abuse in narrowly defined circumstances is an appropriate legal response to the raging epidemic of substance abuse during pregnancy. The Majority of the Supreme Court of Canada has now declared that the common law cannot be extended to provide legal protection to the unborn child from substance abuse during pregnancy. Rather, the Majority urged the elected legislatures, and not the courts, to address this critical problem. And for good reason. The additional facts described in the Minority judgment illustrate the devastating implications of substance abuse during pregnancy. Children suffering from physical and mental disabilities as a result of substance abuse during pregnancy was described as a "crisis situation" in many aboriginal communities. Fetal Alcohol Syndrome (hereinafter FAS) was described as the leading preventable cause of mental disability in the western world. Many secondary disabilities associated with children born suffering from substance abuse during pregnancy were also described including a high prevalence of mental illness, trouble with the law, incarceration for mental illness or crime, inappropriate sexual behavior, alcohol or drug problems, inadequate education, an inability to live independently and unemployment or underemployment. It is indisputable that the tragedy of substance abuse during pregnancy "is felt not just by its immediate victims, but is also born by society as a whole."[3]

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[1] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) at para. 26 [hereinafter *DFG* cited to (1997) S.C.J. No. 96 (QL)].

[2] *Ibid.*

While it is clear that because of the magnitude and complexity prenatal substance abuse it is preferable for the legislatures to address this problem, the Minority judgment raises the critical question of whether legislative inaction is an excuse for judicial inaction. In so doing, it also challenges the Majority's reasons for concluding that the common law cannot be extended to provide legal protection for the unborn child from substance abuse during pregnancy. Should the "born alive" rule or the "slippery slope" argument bar judicial intervention to provide legal protection for the unborn child from substance abuse during pregnancy? What general principles should govern judicial extension of the common law to provide legal protection of the unborn child? How should arguments concerning freedom of choice influence the Court's decisions concerning judicial intervention to prevent substance abuse during pregnancy? What is the relevance of the abortion controversy?

DFG also raises the question of how Canadian legislatures should respond to the "ravages of addiction" during pregnancy? The Majority decision suggests that Canada must rise to the challenge of law reform by broadening its perspective beyond the usual "woman's rights" versus "fetal rights" issues by also focusing on the tremendously complex nature of chronic and severe addiction.

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[3] *Ibid.* at para. 88.

An approach focused on the "ravages of addiction" suggests that substance abuse during pregnancy actually does not involve the commonly perceived dilemma described as follows by the Manitoba Court of Appeal:[4]

> Here is a classic dilemma. An expectant mother sniffs solvent to the probable detriment of her unborn child. If nothing is done, the child when born will surely suffer. Yet, anything which can be done necessarily involves restricting the mother's freedom of choice and, if she persists in the habit, her liberty.

By focusing on the nature and destructive implications of addiction, as did the trial judge and the Minority of the Supreme Court of Canada, the view that emerges is that individuals suffering from chronic and severe addiction have already lost their freedom of choice to the bondage of addiction. Legal intervention to assist women recover from addiction, and, thereby, prevent substance abuse during pregnancy, has the potential to promote the best interests of both mother and unborn child.

This chapter commences with a brief overview of the *DFG* case at each level of Court.[5] The focus of the chapter is a comparative analysis of the Majority and Minority decisions of the Supreme Court of Canada. The position developed is that it is now beyond dispute in Canada that legislative intervention is necessary to address the epidemic of prenatal substance abuse. Claims that legislative intervention to provide legal protection for the unborn child cannot withstand review pursuant to the *Canadian Charter of Rights and Freedoms*[6] are now of little authority. Otherwise, why would the Supreme Court of Canada so adamantly urge the legislature to address this problem? While the author condones the bold message from the Majority concerning the need for legislative intervention, the author also supports the Minority position that the *parens patriae* jurisdiction may be properly extended in this case to protect the unborn child from substance abuse during pregnancy in the event that legislative intervention is not available.

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[4] *Ibid.* at para. 1 cited to M.J. No. 398 (QL).

[5] This overview is intended to compliment the overview of *DFG* described at the after the introduction to chapter two.

[6] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B of the *Canada Act 1982* (U.K.) 1982, c. 11 [hereinafter the *Charter*].

II. THE DECISION OF THE MANITOBA COURT OF QUEEN'S BENCH

Justice Schulman's decision to invoke the *Mental Health Act*[7] and the *parens patriae* jurisdiction as a basis for granting an order for mandatory treatment for chronic and severe substance abuse was enlightening. Typically, the courts have approached the issue from a rights-based perspective. The focus has been on the need to balance a woman's right to freedom of choice and reproductive autonomy versus the need to offer legal protection to the unborn child. To the contrary, Justice Schulman focused on the nature and treatment of substance abuse during pregnancy from a multi-disciplinary perspective. By focusing on the root cause of the problem - chronic and severe substance abuse - Justice Schulman's judgment has the potential to make a significant contribution to law reform initiatives concerning the appropriate legal response to substance abuse during pregnancy. The decision supports the view that legal intervention should not be viewed as an infringement of freedom of choice but rather intervention to promote recovery from addiction as well prevention of prenatal substance abuse.

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[7] *Mental Health Act*, R.S.M. 1987, C. m-110 [hereinafter *Mental Health Act*].

A. THE EVIDENCE: A MULTI-DISCIPLINARY PERSPECTIVE OF "THE RAVAGES OF ADDICTION"

The summary of evidence focused on the serious detrimental implications of chronic and severe substance abuse from a multi-diciplinary perspective. Substance addiction had been extremely harmful to Ms. G.'s physical and mental health, and her social well-being. The evidence also illustrated the harmful effects of substance abuse during pregnancy on Ms. G.'s children. Members of the medical profession described the high risk of physical and mental handicaps arising from substance abuse during pregnancy. Indeed, Ms. G.'s children were developmentally delayed and were permanent wards of the Court prior to the age of two.

The significance of the extensive evidence, which focused entirely on the harmful effects of chronic and severe substance abuse on Ms. G., personally, and on her children, must not be underestimated. The sophisticated multi-disciplinary evidence provides a realistic picture of the tragic lives of Ms. G. and her children caused by the "ravages of addiction." [8] This picture in turn provides a basis for understanding why Justice Schulman concluded that Ms. G.'s "present mental state engages the jurisdiction of this court under the *Mental Health Act* and provides a strong *prima facie* foundation for the exercise of [the] court's *parens patriae* powers."[9] Indeed, the trial Court's orders for mandatory treatment for substance abuse, regardless of pregnancy, seems justified from a practical perspective when measured against the tremendously destructive influence of chronic and severe addiction. Clearly, Ms. G. was unable to resolve her severe addiction problem on her own.

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[8] *DFG, supra* note 1 at para. 5.

[9] *Ibid.* at para. 42 cited to M.J. No. 396 (QL).

Rather than the typical approach of considering substance abuse during pregnancy as just another case of "maternal/fetal conflict," and the need to balance women's rights against the rights of the unborn child, Justice Schulman utilized the evidence to highlight the complex and severe problems arising from addiction. The credibility of Justice Schulman's conclusions concerning the severity of Ms. G.'s mental impairment as a result of chronic and severe substance abuse was substantiated by the detailed evidence summarized at trial.

Ms. G.'s two sisters provided evidence indicating that the family was very concerned about her addiction problem. They stated that often when Ms. G. came to visit she was "sniffed up," dazed and smelling of solvents. On occasion, she could "hardly walk or talk." They had tried to persuade Ms. G. to accept treatment for her addiction problem. Two letters signed by family members were admitted as evidence stating that they were in favor of Ms. G. entering a substance abuse program.[10]

The evidence of the Co-ordinator of an alcohol and abuse treatment center indicated that it was willing to take Ms. G. immediately on a residential basis. This program had "some aboriginal staff and a strong cultural content for aboriginal persons."[11] Residents generally stayed three to six months, but a stay of a year or longer was recommended for people with a long history of substance abuse. The Program involved "needs assessments, counselling, group sessions, and senior residents and key workers doing problem solving with other residents."[12] Overall, this evidence established that the proposed intervention was highly supportive and directed at promoting Ms. G.'s recovery.

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[10] *Ibid. at* para. 4.

[11] *Ibid.* at para. 6.

The evidence of the Medical Director of the Chemical Withdrawal Unit at the Winnipeg Health Sciences Center [hereinafter HSC] describing the effects of substance abuse was succinctly summarized in Justice Schulman's judgment.[13] The acute effects of glue sniffing included nausea, vomiting, tremors, blurred vision, joint pain, chest pain, decreased level of consciousness, and seizures which can progress to coma and respiratory or cardiac arrest, leading to death. Kidney, liver and bone marrow failure can also result from chronic use. The most serious organ damage from glue sniffing occurred in the brain and could cause a decrease in intellectual capacity. The cerebellum, the part of the brain which controls motor co-ordination, could be damaged by glue sniffing to the point where the user suffers loss of sensation and generalized muscle weakness.

The evidence submitted by the Head of the Section of Genetics and Metabolism at the HSC concerned the harmful effects occurring to an unborn child whose mother "chronically abuses alcohol or chronically sniffs glue while pregnant."[14] These children exhibit "central nervous system dysfunction, developmental delay, attention deficit disorder, microcephaly, growth deficiency, short palpebral fissures, deep-set eyes, microagnathia, abnormal auricles and small fingernails."[15] It was noted that the unborn child was particularly vulnerable during the first trimester. However, it was also noted that the damage to an unborn child could be reduced if exposure to glue was eliminated during the second and third trimester.[16]

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[12] *Ibid.*
[13] *Ibid. at* para. 7.
[14] *Ibid.* at para. 8.
[15] *Ibid.*

The Director of the Child Protection Center at the HSC submitted evidence based on the hospital files relating to the birth of Ms. G's second and third children. During confinement, on both occasions there was a noticeable odor of solvents indicating that she was a solvent abuser. They also showed that her children were developmentally delayed with a broad range of deficiencies.[17]

A social worker employed by the City of Winnipeg Social Service Department submitted evidence based on her involvement with Ms. G. since 1992. Throughout this period, the social worker was aware that Ms. G. was a chronic abuser of solvents. She had observed Ms. G. prostituting and Ms. G. admitted that she did so in order to purchase solvents. This social worker also indicated that "Ms. G. effectively had consistently refused all offers of services or treatment."[18]

The concluding evidence was that of two psychiatrists relating to examinations performed to determine if they would commit Ms. G. to the psychiatric department of the HSC pursuant to powers under the *Mental Health Act*.[19] They noted that Ms. G. had a long and severe history with solvent abuse. She had engaged in self-mutilation and had made numerous suicide attempts. Indeed, they concluded that she remained a long-term high risk for suicide. When hospitalized from May 28 to June 6, 1996 for treatment of solvent abuse in the Chemical Withdrawal Unit of HSC it was noted that she suffered cerebellar degeneration. On the basis of this evidence, the psychiatrists concluded that

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[16] *Ibid.*

[17] *Ibid.* at para. 9.

[18] *Ibid.* at para. 10.

[19] *Mental Health Act, supra* note 7.

Ms. G. suffered from "chronic solvent and mixed personality disorder, with anti-social and dependent features."[20] However, they determined that there was no evidence that acute psychiatric intervention was necessary at that time. They also expressed the view that they did not have grounds to detain Ms. G. under the *Mental Health Act*.[21]

Justice Schulman's orders for mandatory treatment was the subject of positive comments from Denise Avard of the Ottawa-based Institute of Child Health. Putting Justice Schulman's decision in a positive light, she noted:[22]

> ...the intervention should be looked on as a positive "win -win" strategy that helps the mother overcome her addiction while protecting her child's health...
>
> We have a right to try and support and try to entice somebody to understand that this will be of benefit to both of them...
>
> ...We have a right with anybody who is being violent or delinquent. We have a moral right to support these people if we are a caring society.

On the other hand, Professor Christine Overall, a leading Canadian feminist, was quoted in *Maclean's* as to her feelings of revulsion "at the horrific possibility of a woman subjecting her fetus to the effects of solvent abuse."[23] However, she also criticized the trial Court's order for mandatory treatment for substance abuse:[24]

> I none the less wonder what this might imply about the surveillance and possible future incarceration of other women. How many are you willing to lock up? How far are you willing to go?

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[20] *DFG, supra* note 1 at para. 16 cited to M.J. No. 386 (QL).

[21] *Ibid.*

[22] *Canadian Newswire Release* (6 August 1996).

[23] "Beyond abortion: advances in science leave an old debate in the dust" *Macleans's (Toronto Edition)*, vol. 109 (34) (19 August 1996) 14 at 16.

[24] *Ibid.*

B. SEVERE ADDICTION AND THE MENTAL HEALTH ACT

The first basis for Justice Schulman's orders granting the Agency custody of Ms. G. was section 56 of the *Mental Health Act.* It states that the Court has the power to make an order:[25]

(a) declaring a person to be mentally disordered; and

(b) committing a mentally disordered person to custody.

Section 1 of the Act defines "mental disorder" as:

> ... a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life and except in Part 1 includes mental retardation.

Justice Schulman decided that the psychiatrists opinions that Ms. G. was not mentally disordered within the meaning of the *Mental Health Act* did not bind the Court. Justice Schulman also observed that the psychiatrists did not address whether Ms. G. had a "disorder of thought, mood, perception...that grossly impairs...(her) ability to meet the ordinary demands of life..."[26] He then went on to describe his reasons for concluding that Ms. G. did in fact have a mental disorder:[27]

> My finding is that D.F.G. indeed suffers from a mental disorder within the meaning of the *Mental Health Act.* There is a great deal of evidence to support that conclusion. There is the medical evidence that she suffers from cerebellar degeneration and cognitive impairment. Other facts indicate behavior that is significantly irrational. Evidence of her conduct is relevant in measuring whether the degree of mental disorder caused by this cerebellar degeneration and cognitive impairment falls under the scope of the statute. That evidence establishes that she has consistently tried to end her life, by hanging; has engaged in self-mutilation; and has stopped eating for days on end, without a reason for doing so. In addition, the evidence is that, if she continues to sniff glue and refuse treatment, she will, in the short term, cause herself much more serious physical and

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[25] *Mental Health Act, supra* note 7.

[26] *Ibid.*

[27] *DFG, supra* note 1 at para. 21 cited to M.J. No. 386 (QL).

> mental harm, and before long, death. All this behavior is contrary to what one would reasonably expect of a rational human being. I want to emphasize that irrational behavior *per se* is not justification for finding a person to be mentally disordered. However, it is a legitimate factor to consider in the context of the total picture when deciding this question.

Justice Schulman's reasons for concluding that Ms. G. suffered from a mental disorder under the *Mental Health Act* as a result of chronic and severe substance abuse are compelling. Clearly, the evidence supports a strong argument that Ms. G. suffered from a disorder of thought mood and perception that grossly impaired her ability to meet the ordinary demands of life. Indeed, Justice Schulman's analysis of the highly complex problem of chronic and severe substance abuse during pregnancy in the context of the *Mental Health Act* is consistent with a study of the "use of civil commitment by the states, including obstacles to its wider use"[28] undertaken pursuant to a recommendation of the Bush Administration. This study concluded that "24 states and the District of Columbia have specific, detailed statutory provisions authorizing the involuntary civil commitment of drug-dependent persons either separate from, or joined with, provisions for the commitment of persons with mental illness, alcoholism, or developmental disabilities."[29]

It is established that the well-being of individuals and society is seriously jeopardized by chronic and severe substance addiction. Canadian society has accepted that mandatory intervention pursuant to mental health legislation is appropriate in narrowly defined conditions of acute psychiatric illness. Justice Schulman's decision established that mandatory treatment for prenatal substance abuse in narrowly defined circumstances must be evaluated for its potential to promote the best interests of women, children and society in general.

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[28] The White House, *National Drug Control Strategy* 42-43 (September 1989).

[29] S. Anderson Garcia & I. Keilitz, "Involuntary Commitment of Drug Dependent Persons With Special Reference to Pregnant Women" (1991) 15 (4) Mental and Physical Disability Law Reporter 418 at 419.

C. THE COURTS *PARENS PATRIAE* JURISDICTION TO SUPPORT ORDERS FOR MANDATORY TREATMENT

Justice Schulman's reliance on the *parens patriae* jurisdiction was unprecedented. Justice Schulman himself commented that he was not aware of any previous case in Canada in which a court had made an order for mandatory treatment for substance addiction. Accordingly, he thoroughly examined the grounds established in *Re Eve* [30] by the Supreme Court of Canada for exercise of the *parens patriae* jurisdiction and found that it can "be engaged to protect an adult person who is 'incompetent' to care for his or herself." [31] Justice Schulman then went on to examine the fundamental question of "whether the evidence in the present case provides sufficient proof of incompetence."[32]

Justice Schulman first examined the Supreme Court of Canada's decision in Justice La Forest's discussion of the nature of the *parens patriae* jurisdiction which emphasized that when the courts have exercised the jurisdiction they have "inexorably moved towards a broader discretion, under the impact of changing social conditions and the weight of opinion..."[33]

The requirements of proof of incompetence were then examined in detail. On the question of whether a strong *prima facie* case had been established, Justice Schulman was satisfied that: [34]

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[30] *E. (Mrs.)* v. *Eve*, [1986] 2 S.C.R. 388 [hereinafter *Re Eve*].

[31] *DFG, supra* note 1 at para. 24 cited to M.J. No. 396 (QL).

[32] *Ibid.* at para. 26.

[33] *Re Eve, supra* note 30 at 427.

> ...a strong argument can be made that a person who has suffered cerebellar damage and cognitive impairment which interferes with her ability to meet the ordinary demands of life may well be held at trial to be a person who comes within the umbrella of protection which La Forest J. wrote about in the *Eve* case.

Regarding the requirement of irreparable harm, Justice Schulman came to the inescapable conclusion that Ms. G. would suffer irreparable harm if the injunction was not granted.[35] Because the evidence showed that if the injunction were not granted Ms. G. would damage herself physically and mentally, Justice Schulman also concluded that the balance of convenience favored the granting of the order, even though it would impair Ms. G.'s liberty.[36]

Regarding the requirement of fairness, justice and common sense, Justice Schulman adopted "the view of the law" articulated by "a great jurist, the late Matas J.A.":[37]

> Each case must be decided on a basis of fairness, justice and common sense in relation to the whole of the issues of fact and law which are relevant to the particular case.

Having found in favor of the Agency regarding the requirements of proof, Justice Schulman addressed the final question of whether an injunction should be granted. In addressing this question, Justice Schulman identified the key issue of whether mandatory treatment for substance addiction was appropriate:[38]

> I am not aware of any previous case in Canada in which a court has made an order which has the effect of requiring an adult who has cognitive and cerebellar damage to enter a residential treatment program to address his or her addiction problem.

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[34] *DFG, supra* note 1 at para. 28 cited to M.J. No. 386 (QL).

[35] *Ibid.* at para. 29.

[36] *Ibid.* at para. 30.

[37] *Ibid.* at para. 31.

[38] *Ibid.* at para. 33.

Justice Schulman then distinguished the case of *Re A* where the Court had "rejected an application which bore some resemblance to the facts of this case."[39] In that case "there was no suggestion that the mother was incompetent."[40] Furthermore, in *Re A* :[41]

> ...the agency had asked the court to invoke its *parens patriae* jurisdiction in favor of the child to be born. In the present case, counsel for the Agency and the pleadings seek protection for Ms. G., rather than for her child to be born.

The devastation suffered by Ms. G. and her children as a result of chronic and severe substance abuse provides a compelling foundation for the argument that "the ravages of addiction" rendered Ms. G. incapable of meeting the ordinary demands of life. The physical and mental harm that Ms. G. has imposed upon herself and her children again and again indicates that she was indeed incompetent to change her destructive behavior. The tragedy of Ms. G.'s life, and the lives of her children, which typifies the devastation suffered by all too many who are addicted to substances, or who are dependent on people suffering from addiction, suggests that extension of the Court's *parens patriae* may be justified in rare and extreme cases and with all due caution and attention to the evidence.

A major complicating factor when invoking the *parens patriae* jurisdiction to assist someone who is unable to assist herself is revealed by the decision of the Manitoba Court of Appeal. It concluded that the trial Court was trying to do indirectly, that is protect the unborn child, that which it could not do directly. This conclusion illustrates that since mandatory treatment for substance abuse during pregnancy gives rise to the tremendous controversy related to women's rights versus the rights of the unborn child, it is unlikely that intervention on the basis of the mother's incompetency arising from chronic and severe addiction would be accepted without challenge. Justice Schulman clearly based his orders on his conclusion that Ms. G. was incompetent. However, this reasoning was not given fair consideration by the Court of Appeal. Similarly, it appears that both the Majority and the Minority of the Supreme Court of Canada were confused as to whether the trial Court's Orders were based on the "*parens patriae* jurisdiction- that is the power of the court to act in the stead of a parent for the protection of a child"[42] or whether it relied on the Court's *parens patriae* jurisdiction in lunacy. Both the Majority[43] and the Minority[44] stated that the trial Court relied on the "*parens patriae* power that permits it to act in place of the parent for the protection of the child."[45] It is astonishing that the Supreme Court of Canada came to this conclusion when the trial Court made it blatantly clear throughout the decision that the *parens patriae* jurisdiction was invoked "for protection of Ms. G., rather than for her child to be born."[46] Justice Schulman only briefly addressed the issue of extension of the *parens patriae* jurisdiction over minors in *obiter* in the event that he had exceeded the present jurisdiction of the Court.[47]

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[39] *Re A. (in utero)* (1990), 75 O.R. (2d) 82 [hereinafter *Re A*].

[40] *DFG, supra* note 1 at para. 34 cited to M.J. No. 386 (QL).

[41] *Ibid.*

In view of the controversy related to substance abuse during pregnancy, it would likely be counterproductive in the long run to attempt to utilize the court's *parens patriae* jurisdiction in lunacy to support orders for mandatory treatment of pregnant women as a result of chronic and severe substance abuse. Furthermore, the *parens patriae* jurisdiction cannot be considered an effective legal response to substance addiction during pregnancy because the problem is of epidemic proportions.

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[42] *Ibid.* at para. 6 cited to S.C.J. No. 96 (QL).

[43] *Ibid.*

[44] *Ibid.* at para. 89.

[45] *Ibid.*

[46] *Ibid.* at para. 34 cited to M.J. No. 386 (QL).

[47] *Ibid.* at para. 43.

D. *OBITER DICTUM*

Justice Schulman commenced his *obiter* comments with the observation that if the law did not support his findings there were "good grounds for broadening the scope of *parens patriae* to allow the Court to make an appropriate order to protect the child to be born."[48] The threshold question was described as being to determine on a reasonable basis that the child would be born. Justice Schulman concluded his judgment by stating that if his approach exceeded the present authority of the court "legislative action may be necessary."[49] Indeed, the Minority of the Supreme Court of Canada delivered a compelling judgment describing the "good grounds" for extending the *parens patriae* jurisdiction to the unborn child. This decision will be analyzed later in this chapter.

It is significant that all Courts agreed with Justice Schulman's final *obiter* comment that if his approach exceeded the present authority of the Court "legislative action may be necessary."[50] This fact is highly supportive of the need for further research to assess the potential value of mandatory treatment for prenatal substance abuse.

E. CONCLUSION

Justice Schulman adopted the widely criticized approach of invoking legal frameworks not specifically intended to address the complex problem of substance abuse during pregnancy. Based on his finding of "incompetency" pursuant to Ms. G.'s chronic and severe substance abuse, Justice Schulman relied on mental health legislation and the Court's *parens patriae* jurisdiction in lunacy to support orders committing Ms. G. for mandatory treatment for substance abuse until the termination of her pregnancy. This decision is understandable in light of the detailed evidence which illustrates the tragic implications of chronic and severe substance abuse during pregnancy for both Ms G. individually, and for her children. However, in view of the highly controversial nature of the maternal/fetal relationship, it is clear that it is counter productive to base intervention on the mental impairment of pregnant women caused from chronic and severe substance abuse in the absence of legislation developed specifically for that purpose pursuant to a thorough process of law reform.

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[48] *Ibid.*

[49] *Ibid.*

[50] *Ibid.*

On a positive note, the decision has the potential to make a significant contribution to law reform initiatives in that it focused on the nature and implications of chronic and severe substance abuse during pregnancy rather than approaching the case as just another circumstance of "maternal/fetal conflict."

III. THE DECISION OF THE MANITOBA COURT OF APPEAL

The Court of Appeal adopted an approach of judicial restraint. It concluded that the trial judge erred in granting relief under the *Mental Health Act* and the *parens patriae* jurisdiction in lunacy as there was no evidence of incompetence. Furthermore, the trial Court's order's could not be upheld for the protection of the unborn child.

A. PROTECTION OF THE UNBORN CHILD

Whereas the Queen's Bench decision focused on whether the impairment caused by chronic and severe substance abuse provided a legal basis for Orders for mandatory treatment, the Court of Appeal's judgment was primarily directed at the much more controversial question of whether the Court has authority to "order the mother to undergo treatment, or to refrain from the use of intoxicants, for the protection of the unborn child."[51]

The Court of Appeal concluded that both the court's *parens patriae* jurisdiction over minors and its jurisdiction to restrain a mother's allegedly tortious conduct is "exercisable only after the child is born." [52] As the majority of the Supreme Court of Canada approached these issues in a similar manner to the Court of Appeal, this aspect of the decision will not be examined in this section of the chapter.

B. THE *MENTAL HEALTH ACT* AND THE *PARENS PATRIAE* JURISDICTION

The Court of Appeal briefly considered the trial Court's reasons for invoking the *Mental Health Act* or the *parens patriae* jurisdiction over incompetent adults. Justice Twaddle simply concluded that as the medical evidence did not support the Queen's Bench finding that Ms. G. was mentally disordered within the meaning of the *Mental Health Act,* it followed that the trial court erred in granting relief under the *Mental Health Act* and the *parens patriae* jurisdiction in lunacy. Unfortunately, the Court of Appeal did not consider the extensive and compelling analysis of the evidence undertaken by the trial Court in reaching the conclusion that Ms. G. had been rendered incompetent by her chronic and severe substance abuse. Furthermore, this important issue was not examined by the Supreme Court of Canada as that Appeal was made on the basis of extension of the common law to provide legal protection for the unborn child.

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[51] *Ibid.* at para. 13 cited to M.J. No. 398 (QL).

[52] *Ibid* at para. 15.

The discrepancy between the decisions of the Court of Queen's Bench and the Court of Appeal concerning the legal implications of cognitive and cerebellar damage arising from chronic and severe substance addiction within the meaning of "mental disorder" under the *Mental Health Act*, and "incompetency" as required for the exercise of the Court's *parens patriae* jurisdiction, illustrates the need for a thorough process of law reform to address these fundamental concepts. Does the incompetency arising from chronic and severe alcohol and drug abuse result in a condition that justifies mandatory addiction treatment? Is there a need for pregnancy-specific legislation in view of the high risk of life long harm to the unborn child? These types of complex questions clearly must be addressed from a multi-disciplinary perspective and pursuant to a thorough process of law reform.

C. LEGISLATIVE INTERVENTION

At the conclusion of his decision, Justice Twaddle emphasized that the issue of substance abuse during pregnancy must be addressed by the legislature and not the Courts. In so doing, he implied that the legislature should address this issue in the context of the commitment made by Canadian society to protect the unborn child:[53]

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[53] *Ibid.* at para. 35.

Through its national government, Canadian society has already recognized a need to offer legal protection to an unborn child. The preamble to the Declaration of the Rights of the Child, adopted by the United Nations in 1959 with Canada as a signatory, states:

> "The child, by reason of his physical and mental immaturity, needs special safeguards and care, including legal protection before as well as after birth."
>
> (U.N. Document A/4354 (1959): see also Convention on the Rights of the Child, U.N. Document A/RES/44/25, concluded November 20, 1989; entry into force September 2, 1990; in force in Canada December 13,1991).

D. CONCLUSION

The approach of judicial restraint adopted by the Manitoba Court of Appeal is consistent with contemporary opinion and current trends. Justice Twaddle's decision reflects the position that, notwithstanding the tragedy of the situation, it is not appropriate for the Court to extend legal frameworks not specifically intended to address the complex problem of substance abuse during pregnancy. Mental health legislation, the Court's *parens patriae* jurisdiction and restraint of allegedly tortious conduct are not the appropriate legal mechanisms to address the controversial issue of substance abuse during pregnancy. In the words of Justice Twaddle:[54]

> Whilst the need has thus been recognized, the circumstances and manner in which, and the extent to which, something should be done remains a matter of some controversy. It is not the function of this Court to impose its answers to those questions on society. It is for the legislature alone to decide what, if anything, should be done.

While it is clear that legislative intervention is preferable, as will be elaborated on in the next section of this chapter, the author adopts the reasoning of the Minority of the Supreme Court of Canada that legislative inaction is no excuse for judicial inaction.

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[54] *Ibid.* at para. 36.

Justice Twaddle's suggestion that legislative intervention to prevent substance abuse during pregnancy should be examined in the context of the formal recognition by Canadian society of the need to offer legal protection to an unborn child, may, at a glance, seem incongruent with his decision to allow the appeal and set aside Justice Schulman's orders which had the effect of protecting the unborn child from substance abuse during pregnancy. In fact it was not. The Manitoba Court of Appeal simply concluded that legal protection of the unborn child must be accomplished by the legislature and not the Courts.

IV.) THE DECISION OF THE SUPREME COURT OF CANADA

This section of the chapter commences with an overview of the Majority and Minority judgments. The discussion that follows examines critical issues arising from a comparative analysis of these decisions.

A. THE MAJORITY DECISION

The Majority commenced its reasons with a precise review of the decision of the Court of Appeal. It summarized the Court of Appeals reasons for setting aside the order for detention as follows:[55]

> Given the difficulty and complexity entailed in extension of the law, the task was more appropriate for the legislature than the courts.

The entire judgment of the Majority was in fact directed at emphasizing and elaborating this general proposition. In so doing, the Majority rejected both the law of torts and the *parens patriae* jurisdiction as a basis for extending legal protection to the unborn child.

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[55] *Ibid.* at para. 7 cited to S.C.J. No. 96 (QL).

i. THE LAW OF TORT

The Majority applied the general proposition that the unborn child is not a legal person to arrive at the conclusion that the existing law of tort did not support detention orders of pregnant women as there was no legal person in whose interests a court order could be made. It then addressed the question of whether the law of tort could be extended to permit the trial Court's order. In so doing, it quoted the general principle concerning judicial extension of the common law described in *Watkins* v. *Olafson.*[56]

The Majority summarized the four changes to the law of tort that would have to be made to grant relief and concluded that they were the "sort of changes that should be left to the legislature."[57] When examining whether the rule that rights accrue only at birth should be overturned, the Court focused on the fact that it would "constitute a major departure from the common law as it has stood for decades."[58] The "slippery slope" argument was applied to identify major potential ramifications of such a change.

When examining whether the law of tort should be changed so as to recognize a fetal right to sue its mother, the Majority noted that this would result in the anomaly of permitting "one part of a legal and physical entity"[59] to sue itself. It, therefore, concluded that this change was "better left to the legislature than effected by the courts."[60]

The Majority's reasons against permitting the recognition of a cause of action for lifestyle choices focused on its concern that such actions "would take the Courts into the difficult policy issue of the extent to which a mother's lifestyle is actionable."[61] It was recognized that "the courts, proceeding properly in their incremental law-making capacity, may one day recognize such claims..."[62] However, at this point, the Majority was not prepared "to break new ground in a controversial area"[63] because if it permitted life style actions, it wondered where it would "draw the line?"[64] The Majority rejected the argument that the duty of care could be limited to refraining from activities "that have no substantial value to a pregnant woman's well-being or right of self-determination and that have the potential to cause grave and irreparable harm to the child's life, health and ability to function after birth."[65] Although the Majority acknowledged that it "may be easy to determine that abusing solvents does not add substantial value to a pregnant woman's well being and may not be the type of self-determination that deserves protection,"[66] it was concerned that "other behaviors are not as easily classified."[67] In addition to this slippery slope argument, the Majority also described the following additional factors as having the effect of limiting the mother's duty of care to her fetus: 1) the difficulty determining what will cause grave and irreparable harm to fetus; 2) lifestyle "choices" such as alcohol and drug abuse may be the symptoms of illness rather than free choice and, therefore, there would be little deterrent value in the proposed new duty; 3) recognizing a duty of care in the lifestyle of pregnant women would increase the level of outside scrutiny and therefore exacerbate the pregnant woman's condition rather than improve it and; 4) the evidence before the Court failed to establish that extending tort liability for lifestyle choices of pregnant women would in fact diminish the problem of injured infants. Notwithstanding the Majority's identification of these factors, it stated that the change may be justified if it could be determined that the change would reduce the problem of children damaged from substance abuse during pregnancy.[68] The Majority concluded that as the proposed change to the law of tort had the potential to "produce considerable uncertainty and affect many peoples' lives adversely, without any assurance of reducing the problem of damage to unborn children from substance abuse"[69] it was more appropriate for "the legislature to address the proper remedy for the problem."[70]

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[56] [1989] 2 S.C.R. 750 at 760-61 [hereinafter *Watkins*], approved in *R.* v. *Salituro*, [1991] 3 S.C.R. 654 at 668-69.

[57] *DFG, supra* note 1 at para. 20.

[58] *Ibid.* at para. 22.

[59] *Ibid.* at para. 27.

[60] *Ibid.* at para. 29.

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[61] *Ibid.* at para. 33.

[62] *Ibid.*

[63] *Ibid.*

[64] *Ibid.*

[65] *Ibid.* at para. 38.

[66] *Ibid.* at para. 39.

[67] *Ibid.*

Regarding extending injunctive relief in civil cases to detention of the person, the Majority noted that injunctive relief has never been used to justify forcible detention and mandatory treatment of a person. As this change would involve a "radical extension of civil remedies into the most sacred sphere of personal liberty-- the right of every person to live and move in freedom,"[71] the Majority concluded that it "must be left to Parliament or the legislature."[72]

ii. THE *PARENS PATRIAE* JURISDICTION

The Majority's deliberation of whether the *parens patriae* jurisdiction supported an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to her unborn child was brief. Its reasons for rejecting this proposition were similar to those described for rejecting the argument that the law of tort should be extended to provide legal protection to the unborn child from substance abuse during pregnancy.[73]

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[68] *Ibid.* at para. 43.

[69] *Ibid.* at para. 45.

[70] *Ibid.*

[71] *Ibid.* at para. 46.

[72] *Ibid.*

The Majority examined *Re F* (*in utero*)[74] which was also relied on by the Manitoba Court of Appeal as a precedent for rejecting relief on the basis of the *parens patriae* jurisdiction. It affirmed the view that to utilize the *parens patriae* jurisdiction to sustain the order requested in this case would "interfere with the pregnant woman's ability to choose where to live and what medical treatment to undergo."[75] It therefore concluded that "the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women."[76]

B. THE MINORITY DECISION

The decision of the Minority was compelling. Rather than simply reiterating the overused and often inappropriate arguments arising out of the "maternal rights" versus "fetal rights" debates, the Minority, in the author's view, thoroughly and objectively examined the logic behind these arguments.

i. THE FACTS

Whereas the Majority found "little point in minutely canvassing the facts," Justice Major reviewed in detail the evidence summarized at trial. Additional facts were also presented. When Ms. G. was 16 years old, abusing solvents, and pregnant with her first child, she was deemed "a child in need of protection" and placed in a residential youth treatment facility.[77] Justice Major also commented that during this pregnancy, Ms. G. had consented to placement in a residential treatment centre program for substance abuse, but when the social worker returned to transport her to the facility she refused because she was "obviously intoxicated."[78] Finally, Justice Major noted that since the delivery of Ms. G.'s apparently healthy baby boy she had had 24-hour in-home support to assist her in parenting the child. At the date of the hearing before the Supreme Court of Canada, the evidence was that Ms. G. no longer abused solvents.[79]

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[73] *Ibid. at* para. 50.

[74] [1988] 2 All E.R. 193 [hereinafter *Re F*].

[75] *DFG, supra* note 1 at para. 56.

[76] *Ibid.*

ii. ADDITIONAL FACTS

Justice Major summarized the additional evidence of several intervenors indicating the high prevalence of mental and physical disabilities in children as a result of substance abuse during pregnancy. He specifically noted that some of the evidence focused on the "crisis situation" in many aboriginal communities. This evidence will be quoted in detail in view of its relevance to this thesis:[80]

> (i) There is clear and overwhelming evidence that abuse of substances (alcohol, solvents, gasoline, etc.) by pregnant women can lead to fetal alcohol syndrome ("FAS") or fetal alcohol effects ("FAE"). Moffatt et al. in *Fetal Alcohol Syndrome, Fetal Alcohol Effects and the Impact of Alcohol Exposure during Pregnancy on School Performance and Behavior in School-Age Children in a First Nation Community* (November 1996 (the "Moffatt Report")), comment, at p. 4, that:

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[77] *Ibid.* at para. 68.
[78] *Ibid.* at para. 77.
[79] *Ibid.* at para. 87.
[80] *Ibid.* at para. 88.

> Children of women who drink heavily during pregnancy are at risk for a cluster of anomalies which include central nervous dysfunction leading to developmental and cognitive impairment.....
>
> The tragedy of the lives of FAS children is all too well documented in the popular book "The Broken Cord" by Dorris. They have learning problems and difficulty with ordinary social relationships. They have special problems anticipating the consequences of their actions. They frequently have poor concentration and hyperactive behavior...Their personalities often lead them into situations where they are exploited sexually and in other ways.

(ii) The Manitoba Children and Youth Secretariat in *Strategy Considerations for Developing Services for Children and Youth* (March 1997), describes FAS, at p. 15, as "the leading preventable cause of mental disability in the western world".

(iii) In addition to the direct health implications that substance abuse has on the body and mind of the foetus, there are many secondary disabilities associated with children born suffering from their mother's abuse....It goes without saying that the tragedy of FAS/FAE is felt not just by its immediate victims, but is also born by society as a whole.

(iv) The tragedy of FAS and FAE is particularly felt in aboriginal communities. The Manitoba Tribal Council NADAP Coordinators and Treatment Directors Committee responded to the Moffatt Report in part by stating that:

> There is documented confirmation the FAS/E rates on Reserve - 17 in 179...are disturbingly higher than the provincial average of 1 in 600...The information is telling us [sic] there is a crisis for these children and families. There is no indication the rate will slow down.

The Royal Commission on Aboriginal Peoples recorded the following testimony, in vol. 3, *Gathering Strength* (1996), at pp. 132-33:

> Children with FAS or FAE are often difficult babies, especially if they are withdrawing from the alcohol that surrounded them in the (womb). If the mothers are still actively abusing alcohol, these children are often subject to attachment breaks, abuse, and/or neglect, and they often become involved with the child welfare system as foster or adopted children.

> The Manitoba Tribal Council NADAP Coordinators and Treatment Directors Committee urged "strategies to intervene and prevent FAS/E."
>
> (v) The intervenors Southeast Child and Family Services and West Region Child and Family Services are aboriginal child and family service agencies responsible for delivering services to 18 First Nation communities in Manitoba. These parties intervened, in part, to urge upon this Court the creation of a legal remedy to use in their fight against FAS/FAE. These intervenors submitted that such a remedy would be consistent with the aboriginal world view, and that the common law should be expanded to help alleviate what is particularly and aboriginal problem.

iii. THE BREADTH OF THE *PARENS PATRIAE* JURISDICTION

The introduction to Justice Major's analysis of the *parens patriae* jurisdiction described the points that would be expanded on in the remainder of the judgment. It included the following summary of the minimum thresholds that would have to be met to justify state intervention:[81]

> (1) The woman must have decided to carry the child to term.
>
> (2) Proof must be presented to a civil standard that the abusive activity will cause serious and irreparable harm to the foetus.
>
> (3) The remedy must be the least intrusive option.
>
> (4) The process must be procedurally fair.

In describing the breadth of the *parens patriae* jurisdiction, Justice Major cited several observations made by the Supreme Court of Canada in *Re Eve*[82] concerning its history and scope which may be summarized as follows:[83]

> 1. The *parens patriae* jurisdiction is available to address uncontemplated situations when it is necessary to protect those in its ambit even where there is legislation in an area.

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[81] *Ibid.* at para. 96.

[82] *Re Eve*, *supra* note 30.

[83] *DFG*, *supra* note 1 at para. 100.

> 2. The fact that the *parens patriae* jurisdiction had not been utilized to support orders for medical procedures prior to *Re Eve* may be explained by "the state of medical science at the time."
>
> 3. It is impossible to define the limits of the *parens patriae* jurisdiction. Each case depends on its own circumstances.
>
> 4. The *parens patriae* jurisdiction is founded on the necessity to protect those who cannot care for themselves.
>
> 5. The *parens patriae* jurisdiction has constantly moved towards a broader discretion under the impact of changing social conditions.
>
> 6. The *parens patriae* jurisdiction has always been described as being of the widest nature. That the courts are available to protect children from injury is no modern development.
>
> 7. Orders under the *parens patriae* jurisdiction can be made to forestall anticipated harm.

Justice Major then noted that after *Re Eve* it was unclear if the *parens patriae* jurisdiction applied to the unborn child. He dismissed *Re F*[84] and the decision of the Manitoba Court of Appeal in this case as authorities for the proposition that it does not. These decisions wrongly relied on the "born alive" rule which, in Justice Major's view, was a common law evidentiary presumption rooted in rudimentary medical knowledge that has long since been overtaken by modern science.

iv. THE "BORN ALIVE" RULE

Justice Major first noted that although the Manitoba Court of Appeal relied on this rule, "no inquiry was made into the genesis or purpose of the rule."[85] He then discussed a "pervasive" article on this topic by Clarke Forsythe[86] which traced the genesis of this rule and concluded that it was:[87]

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[84] *Re F, supra* note 74.

[85] *DFG, supra* note 1 at para. 104.

[86] C. D. Forsythe, "Homicide of the Unborn Child: The Born Alive Rule and Other

> evidentiary, rather than substantive, a principle necessitated by the primitive medical knowledge and technology of the time.

Justice Majors quoted several authorities cited by Forsythe to explain and elaborate on this conclusion.

When considering the rule from a more modern perspective, Justice Major noted that some American States had distinguished the rule.[88] Canadian authorities were also examined. It was noted that in *R* v. *Sullivan*[89] it was simply decided that the wording of section 26 of the *Criminal Code* adopted the "born alive" rule for purposes of the *Criminal Code*. It was also noted that the Supreme Court of Canada in *Montreal Tramways Co.* v. *Leveille*[90] and *Duval* v. *Seguin*[91] had already recognized the need to re-evaluate the "born alive" rule due to advances in medical technology.

Justice Major distinguished *Daigle*[92] which applied the "born alive" rule as a bar to obtaining an injunction preventing pregnant woman from undergoing an abortion from the case at hand on the basis that Ms. G. had chosen to carry her child to term. The minimal requirement of women who had decided to carry the pregnancy to term was to refrain from the abuse of substances "that have, on proof to the civil standard, a reasonable probability of causing serious and irreparable damage to the foetus..." [93] It was also noted that this approach was endorsed by the Supreme Court of Canada in *Daigle* because

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Legal Anachronisms" (1987) 21 Val. U.L. Rev. 563 [hereinafter "Legal Anachronisms"].

[87] *DFG, supra* note 1 at para. 105.

[88] *Ibid.* at para. 111.

[89] [1991] 1 S.C.R. 489 [hereinafter *Sulivan*].

[90] [1933] S.C.R. 456 [hereinafter *Montreal Tramways*].

[91] (1972), 2 O.R. 686, aff'd (1973), 1 O.R. (2d) 482 [hereinafter *Duval*].

[92] *Tremblay* v. *Daigle*, [1989] 2 S.C.R. 530 [hereinafter *Daigle*].

[93] *DFG, supra* note 1 at para. 116.

protection of the unborn child from substance abuse during pregnancy is necessary to protect its interests after it was born.[94]

In conclusion, Justice Major declared that "rigidly applying precedents of questionable applicability without inquiry will lead the law to recommit the errors of the past."[95] In this regard, Justice Major referred to the infamous "persons"[96] case where the Supreme Court of Canada unanimously held that the word "person" in the *British North American Act* did not include women.

v. STANDARD FOR EXERCISING JURISDICTION

Justice Major concluded that it was only a "modest expansion on La Forest J.'s statement in *Re Eve,* to include a foetus within the class of persons who can be protected by the exercise of the *parens patriae* jurisdiction."[97] The jurisdiction was exercised only "in extreme cases where the conduct of the mother has a reasonable probability of causing serious irreparable harm to the unborn child..."[98] He emphasized that this jurisdiction would not interfere with women's decision of whether to have an abortion or to carry a pregnancy to term.

Justice Major further addressed the concern that exercise of the *parens patriae* jurisdiction would infringe on some rights of the mother by stating that it is well established in our society if our behavior harms others it may be properly restrained. It therefore followed that, in view of the risk of serious harm to the unborn child from substance abuse during pregnancy, confinement is justified when it is the only effective solution.

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[94] *Daigle, supra* note 92 at 563.

[95] *DFG, supra* note 1 at para. 118.

[96] *Edwards* v. *Attorney-General for Canada,* [1930] A.C. 124, rev'g [1928] S.C.R. 276 [hereinafter *Edwards*].

[97] *DFG, supra* note 1 at para. 121.

[98] *Ibid.*

vi. CONCLUSION

Justice Major succinctly described the procedural requirements. Standing was to be determined on a case-by-case basis. It was to be utilized only in extreme cases where the conduct of the mother had a reasonable probability of causing serious and irreparable harm to the unborn child, and no other means of reasonable treatment existed. Procedural fairness could be governed by *The Court of Queen's Bench Act*[99] and the *Court of Queen's Bench Rules*[100] in this case.

Justice Major concluded the judgment by acknowledging that it may be preferable that the legislature act. However, "its failure to do so is not an excuse for the judiciary to follow the same course of inaction."[101]

The Supreme Court of Canada decision in *Montreal Tramways*[102] was then discussed to explain why the majority of that Court in 1939 went against "the great weight of judicial opinion in the common law courts which denied the right of a child when born to maintain an action for pre-natal injuries."[103] If the unborn child injured as a result of the wrongful act of another was not entitled to maintain an action for prenatal injuries, it would have "to go through life carrying the seal of another's fault and bearing a very heavy burden of infirmity and inconvenience without any compensation therefor."[104]

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[99] *The Court of Queen's Bench Act*, C.C.S.M., c. C280.
[100] *Court of Queen's Bench Rules*, Man. Reg. 553/88.
[101] *DFG, supra* note 1 at para. 138.
[102] *Montreal Tramways, supra* note 90.
[103] *Ibid.* at 460.

In allowing the appeal and declaring that the trial Court was within it jurisdiction under the *parens patriae*, Justice Major declared that granting the limited intervention served the interest of:[105]

> (a) the mother as her option for an abortion is always available,
>
> (b) protecting the foetus from serious and irreparable harm and permits it a reasonable chance of having a normal life after birth,
>
> (c) preventing unnecessary spending by Canadian governments to permanently care for the mentally disabled child born as a result of the mother's unrestricted drug addiction.

C. ANALYSIS

i. INTRODUCTION

In the wake of *DFG*, we see that once again the question of legal protection for the unborn child has been left to the legislatures. *Morgentaler*[106] has been described as "an act of judicial statesmanship"[107] that should have "forced Canadian lawmakers to deal with the abortion issue..."[108] And yet, a decade later, there has been no progress whatsoever, and the abortion controversy rages on. The Majority decision in *DFG* may be viewed as a similar, but much more direct and aggressive act of judicial statesmanship. There is really little more that the Supreme Court of Canada could have said in that decision to urge the legislatures to address the issue of legal protection for the unborn child.

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[104] *Ibid.*

[105] *DFG, supra* note 1 at para.142.

[106] *R* v. *Morgentaler*, [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].

[107] F.L. Morton, "The Meaning of *Morgentaler: A* Political Analysis," in I. Gentles ed., *A Time To Choose Life* (Toronto: Stoddart Publishing Company, 1990) 168 at 184.

[108] *Ibid.*

The Majority decision in *DFG* may also be considered a political decision directed at excusing the Courts of responsibility for addressing a tremendously controversial issue. A controversy viewed by many as a battle of fundamental rights between mother and unborn child. However, in light of Canadian lawmakers unwillingness or inability to address issues involving the maternal/fetal relationship, the question arises if it was wise to leave the problem of substance abuse during pregnancy for the legislatures to address. Likely not. Particularly in view of the fact that the reasoning of the Majority to support its decision relied primarily on the questionable "born alive" rule and "slippery slope" argument in "blind imitation of the past."

The Minority decision was a surprising and compelling challenge of the common misconceptions that have enabled the Courts, including the Majority in *DFG*, to turn a blind eye on the issue of legal protection of the unborn child. It was as shocking as it was commendable that the Minority went so far as to objectively evaluate, and ultimately invalidate, the arguments that the Courts have typically relied on in order to avoid having to address the tremendously political and volatile issues concerning the unborn child. And yet it did so for good reason: "someone must speak for those who cannot speak for themselves."[109] It is unfortunate that the Majority did not address many of the arguments raised by the Minority. Rather, the Majority invoked questionable legal arguments to support its conclusion that "the changes to the law sought on this appeal are best left to the wisdom of the elected legislature."[110]

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[109] *DFG, supra* note 1 at para. 140.

The following remarks elaborate six of the more important points gleaned from a comparative analysis of the Majority and Minority judgments indicating that although the Majority's unprecedented "demand" for legislative intervention was commendable, and although legislative intervention is preferable, "its failure to do so is not an excuse for the judiciary to follow the same course of inaction."[111] While it is indisputable that initiatives to prevent substance abuse during pregnancy must be primarily directed at "counselling, rehabilitation, outreach and support services designed specifically to meet the needs of pregnant women with drug/alcohol addictions,"[112] judicial intervention in rare and extreme cases must be available to the state for it to enforce its "interest in ensuring, to the extent practicable, the well being of the unborn child..."[113]

ii. CATALYST FOR LEGISLATIVE INTERVENTION

Justice McLachlin's judgment on behalf of the Majority is radical in that it repeated almost 20 times, in an otherwise concise judgment, that an order for the detention of pregnant women for the purpose of preventing harm to her unborn child requires changes to law which are "best left to the wisdom of the elected legislature." The fact that the Court was compelled to repeat itself as never before, raises the question as to why the

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[110] *Ibid.* at para. 59.

[111] *Ibid. at* para. 138.

[112] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) 965 [hereinafter "the Report"]. The recommendations to prohibit judicial intervention during pregnancy are described in chapter 30, vol. 2 of the Report at p. 949-65. Dr. Scorsone's dissenting view is presented at pages 1123-43.

[113] *DFG, supra* note 1 at para. 66.

Court deemed it necessary to constantly restate that the legislatures, and not the Courts, are responsible law reform concerning legal protection for the unborn child.

The most likely reason for the repetition is the legislative inaction subsequent to *Morgentaler.*[114] Harvard law professor, Mary Ann Glendon, commented that in striking down the *Criminal Code* regulation of abortion, the Supreme Court of Canada in *Morgentaler* "scrupulously rested its holding on narrow grounds, leaving the legislature with wide latitude to fashion a new system of abortion regulation."[115] Professor Glendon agreed with an American commentator that this Supreme Court of Canada decision was:[116]

> ...a provisional ruling, a ruling that invited Parliament to reconsider the question of abortion, perhaps with a more informed and thoughtful understanding of the relevant competing interests.

And yet, a decade later, Canadian legislators have not enacted a new abortion statute nor have they made any progress whatsoever toward that end. The result being, as noted by Professor Morton, the present "non policy" approach to abortion has left Canada "as the only Western democracy not to provide at least symbolic support for the unborn child while still respecting a woman's freedom to choose."[117] Because the Supreme Court of Canada's "provisional ruling" has been so distorted and manipulated by the raging "pro-life" and "pro-choice" debates, it is no wonder that the Majority was determined to make itself perfectly clear that the decision was neither a denial of fetal rights nor an affirmation of women's right to absolute freedom of choice.

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[114] *Morgentaler, supra* note 106.

[115] M.A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: The Free Press, 1991) at 165 [hereinafter *Rights Talk*].

[116] D. O. Conkle, "Canada's *Roe*: The Canadian Abortion Decision and its Implications for American Constitutional Law and Theory" (1989) 6 *Constitutional Commentary* 299 at 311.

[117] F.L. Morton, *Morgentaler* v. *Borowski: Abortion, the Charter and the Courts.* (Toronto: McClelland and Stewart, 1992) at 313 [hereinafter *Morton*].

The Majority's dramatic emphasis that it is for the legislatures, and not for the Courts, to address the issue of legal protection of the unborn child may also be in response to how "the marked increase in the assertion of rights based claims... and parallel increase in recognition of those claims in the courts" [118] produced what Professor Glendon described as a revolutionary change in the roles of the Court and judges:[119]

> Court majorities with an expansive view of the judicial role, and their academic admirers, propelled each other, like railwaymen on a handcar, along the line that led to the land of rights.

The result of this change in the States was that "many hopeful men and women came to believe that the high road to a better society would be paved with court decisions..."[120] It followed that the "time-honored understanding that difficult and controversial issues"[121] are to be addressed by the legislature began to erode:[122]

> To many activists, it seemed more efficient, as well as more rewarding, to devote one's time and efforts to litigation that could yield total victory, than to put in long hours at political organizing, where the most one can hope to gain is, typically, a compromise. As the party system gradually fell prey to large, highly organized, and well-financed interest groups, regular politics came to seem futile as well as boring, socially unproductive as well as personally unfulfilling.

Indeed, it is clear that this view of law and politics influenced thestrategy of abortion rights activists in Canada in their decision to pursue *Morgentaler* to the Supreme Court of Canada. That decision is typically viewed by abortion rights activists as an absolute victory. However, the fact is that the decision was written in such a way as "to leave maximum leeway to legislative decision-making."[123] Furthermore, Chief Justice Dickson emphasized that "courts are not the appropriate forum for articulating complex and controversial programmes of public policy."[124] It is no wonder the Supreme Court of Canada in *DFG* went to great extremes to assert the appropriate role of the courts and the legislatures regarding complex social issues.

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[118] *Rights Talk, supra* note 115 at 4.
[119] *Ibid.* at 7.
[120] *Ibid.* at 6.
[121] *Ibid.*
[122] *Ibid.*
[123] *Ibid.* at 164.

The misconceptions propagated by stakeholders in the abortion debate, including the concept that the unborn child is not entitled to common law nor legislative protection, may explain why the Majority deemed it necessary to highlight the fact that although the common law does not recognize the unborn child as a legal or juridical person, the legislatures may legislate legal protection for the unborn child:[125]

> If Parliament or the legislatures wish to legislate legal rights for unborn children or other protective measures, that is open to them, subject to limitations imposed by the Constitution of Canada.

Clearly, in the wake of *DFG*, arguments that legislative intervention to provide legal protection for the unborn cannot withstand *Charter* scrutiny will carry little weight.[126]

The context in which the Majority declared that the legislatures, and not the Courts, are responsible for addressing the issue of substance abuse during pregnancy provides valuable direction for law reform. The Majority was particularly directive in its response to the argument that the "live-birth" rule should be overturned because the existing law does not provide a remedy. It concluded that "this argument begs the question of whether a remedy is required"[127] and then answered this question by declaring that "it is not every evil which attracts court action; some evils remain for the legislature to correct."[128] It further implied that the appropriate correction would be to "introduce a law permitting action to protect unborn children against substance abuse"[129] which was limited to that precise case. These comments from the Majority decision, considered in the context of the Minority's reasons which established that the "born alive" rule is outdated and indefensible, lead to the inescapable conclusion that Canada must critically examine the American precedents which, "armed with today's medical knowledge have stepped forward and distinguished the rule."[130]

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[124] *Morgentaler, supra* note 106 at 46.

[125] *DFG, supra* note 1 at para. 12.

[126] For an interesting discussion of s.1 of the *Charter* as justification for unwanted medical treatment of pregnant women see: M. Jackman, "The Canadian Charter as a Barrier to Unwanted Medical Treatment of Pregnant Women in the Interests of the Foetus" (1993) 14 (1) Health Law In Canada 49 at 54. Jackman notes that the *Morgentaler* decision indicates "that foetal protection is a sufficiently important legislative objective" as required by *R.* v. *Oakes*, [1986] 1 S.C.R. 103 at 138-40 which established the test for determining whether a violation of a *Charter* right can be saved under s. 1.

The Majority referred to the *Mental Health Act* on several occasions. For example, in its reasons for deciding that the *parens patriae* jurisdiction should not be extended to provide legal protection for the unborn child, the Court quoted from *Re F (in utero)* where Justice Balcombe recommended:[131]

> ...under the *Mental Health Act 1983,* to which we were also referred, there are elaborate provisions to ensure that persons suffering from mental disorders or other similar conditions are not compulsorily admitted to hospital for assessment or treatment without proper safeguards... If Parliament were to think it appropriate that a pregnant woman would be subject to controls for the benefit of her unborn child, then doubtless it will stipulate the circumstances in which such controls may be applied and the safeguards appropriate for the mother's protection.

The Majority later reiterated this position in its declaration that "If a pregnant woman was to be subject to controls for the benefit of her unborn child, Parliament should so legislate, as it had in the case of mentally incompetent persons."[132] Dr. Scorsone, in her dissenting opinion in the Report, also suggested that a mental health approach to substance abuse during pregnancy was appropriate:[133]

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[127] *DFG, supra* note 1 at para. 26 cited to S.C.J. No. 96 (Ql).

[128] *Ibid.*

[129] *Ibid.* at para. 24.

[130] *Ibid.* at para. 111.

[131] *Re F, supra* note 74 at 200-01.

> The question must arise whether severe drug addiction resulting in incoherence or uncontrollable compulsion is sufficiently parallel to or cognate with severe mental illness in some respects that similar approaches are appropriate.

It is entirely reasonable that a mental health framework was suggested when the fact is that mental health legislation or legislation specific to drug abuse is utilized as a basis for civil commitment of individuals with severe addiction problems in many jurisdictions around the world.[134] However, this approach has not been adopted in Canada.

The Majority affirmed Hanigsberg's view that "a product of addiction is the inability to control in-take of the substance being abused..."[135] The Majority also referred to addiction being the product of "illness rather than free choice."[136] The question therefore arises as to why the Majority referred to the need to balance the competing interests of mother and unborn child. Where then are the competing interests when the intervention is directed both at assisting pregnant women recover from their addiction and at preventing permanent damage to future members of society?

Canadian legislatures and Courts would be well advised to consider Professor Glendon's insights concerning the downside of "rights talk" which illustrates that legislators should avoid rights-based strategies so as not to reach a nonnegotiable deadlock of competing interests and rights.[137] When addressing the complex social

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[132] *DFG, supra* note 1 at para.53.

[133] Report, *supra* note 112 at 1127.

[134] B. Brown, "Civil Commitment - An International Perspective" (1988) 18 (4) The Journal of Drug Issues 663 at 666.

[135] J.E. Hanigsberg, "Power and Procreation: State Interference in Pregnancy" (1991) 23 Ott. L. Rev. 35 at 53 [hereinafter "Power and Procreation"].

[136] *DFG, supra* note 1 at para. 41.

problem of addiction, including mandatory treatment for prenatal substance abuse, what is needed is "serious and sustained political discussion" that is focused on the promotion of human dignity rather than the assertion of "fetal rights" versus "maternal rights."

iii. JUDICIAL EXTENSION OF THE COMMON LAW

The Majority decision that the law of tort and the *parens patriae* jurisdiction over minors should not be extended to provide legal protection of the unborn child from substance abuse during pregnancy was, in part, based on the general principle that the "courts will not extend the common law 'where the revision is major and its ramifications complex.'"[138] The Supreme Court of Canada decision in *Watkins*[139] was quoted as the precedent for this general proposition. Ironically, the general principle actually declared in that decision, and quoted by the Majority, was that "where the revision is major and its ramifications complex, the courts must proceed with great caution."[140] Indeed, the Minority applied the rule actually declared in *Watkins* and "proceeded with great caution" in its decision to extend the *parens patriae* jurisdiction. This discrepancy raises issues about how the rule should be properly described and whether the common law should be extended to provide legal protection for the unborn child.

The Majority's decision to change the general principle and declare that the Courts **will not** extend the common law where "the revision is major and the ramifications complex" is consistent with its emphasis that the legislature, and not the Courts, should

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[137] *Rights Talk, supra* note 115 at 66.
[138] *DFG, supra* note 1 at para. 18.
[139] *Watkins, supra* note 56.
[140] *Ibid. at* 76.

address the issue of legal protection for the unborn child. Similarly, the Minority's reliance on the original principle that the Courts must "proceed with great caution" is consistent with its view that legislative inaction is not an excuse for the judiciary to follow the same course of inaction. The analysis that follows establishes that the Minority appropriately applied the original general principle, proceeded with great caution, and properly extended the common law.

The Minority decision was developed on the fundamental concept that the much admired flexibility of the common law was required for the purposes of this case. It therefore proceeded with great caution and developed the minimum threshold that would have to be met to justify state intervention. In so doing, Justice Major emphasized that the threshold is high because the mother's liberty is at stake and "each case will have to be decided on its facts."[141] The Minority's conclusion summarizing why the minimum threshold had been met in this case exemplified the value of allowing the Courts to "proceed with great caution" even when the changes to the common law are major:[142]

> When confinement is determined to be the only solution that will work in the circumstances, this type of imposition on the mother is fairly modest when balanced against the devastating harm substance abuse will potentially inflict on her child. The afflicted children may be sentenced to a permanently lower standard of life. To advocate not confining the mother to prevent this harm seems extreme and shortsighted.

The need to maintain the flexibility of the common law is also highlighted by Justice Major's speculation of "what the result of this appeal might have been, had the state been trying to restrain a pregnant mother from taking thalidomide to deal with her morning sickness."[143]

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[141] *DFG, supra* note 1 at para. 95.

[142] *Ibid.* at para. 132.

[143] *Ibid.* at para. 123.

Some may argue that the minimum threshold described in the Minority decision is too vague to properly address the complex issues related to judicial extension of the *parens patriae* jurisdiction. However, these arguments are answerable. Justice Major emphasized that each case has to decided on the facts. Furthermore, the Majority applied the test established in *City of Kamloops* v. *Nielson*[144] to determine if the Court should impose a duty of care in a new situation. This test provides no more certainty than does the minimum threshold developed by the Minority in *DFG*. Finally, the Minority did not claim that extension of the *parens patriae* jurisdiction is the most appropriate approach to substance abuse during pregnancy. On the contrary, Justice Major implied that legislative intervention was preferable.[145]

The tragedy of Ms. G.'s life described in the summary of evidence, and the well-documented high "prevalence of mental and physical disabilities in children as a result of substance abuse by their mother while pregnant"[146] described in the additional facts is also highly supportive of the approach to judicial extension of the *parens patriae* jurisdiction adopted by Justice Major. The fact that intervenors in the appeal to the Supreme Court of Canada on behalf of 18 First Nation Communities in Manitoba urged for a legal remedy to assist them in there fight against Fetal Alcohol Syndrome and Fetal Alcohol Effects is also consistent with the approach to judicial extension adopted by Justice Major.[147] Indeed, it is not surprising that these intervenors have taken this position. The information summarized by Justice Major as additional facts indicates that the prevalence of mental and physical disabilities in children as a result of substance abuse by their mothers while pregnant has reached a "crisis situation in many aboriginal communities."[148]

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[144] *Kamloops (City of)* v. *Nielson*, [1984] 2 S.C.R. 2.

[145] *DFG, supra* note 1 at para.138.

[146] *Ibid.* at para. 88.

[147] *Ibid.*

Justice Major's reasons for concluding that the *parens patriae* jurisdiction should be extended to provide legal protection for the unborn child from substance abuse during pregnancy are particularly convincing in light the Majority's debateable reasons for concluding that it should not. First, the Majority failed to address the fact that it had changed the general principle concerning judicial extension of the common law. Clearly, the Majority should have explained its decision to prohibit judicial extension of the common law when the changes are major rather than reiterate the rule actually declared in *Watkins* that the Courts must proceed with great caution in such circumstances. Particularly in light of the fact that the new rule declared by the Majority is not consistent with the much-admired adaptability of the common law. What could the Courts do when faced with a case involving a highly confused pregnant woman who was not legally incompetent, but who was unable to appreciate the harm caused to her unborn child by a particular over-the-counter medication, and therefore insisted on taking the medication throughout her pregnancy? Furthermore, the Majority did not address the issue of how to draw the line between "major changes with complex ramifications" and other changes that may be properly made by the Court. It is therefore arguable that the Majority's new description of the general principle concerning judicial extension of the common law has only further confused an already complex area of law. Finally, the Majority judgment did consistently apply the new principle that the courts will not extend the common law where the revisions are major and the ramifications complex.

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[148] *Ibid.*

The Majority's examination of the issue of extending tort liability to life style choices relied, in part, on the original general principle declared in *Watkins* rather than on its pronouncement of the new principle. The Majority acknowledged that recognizing a duty of care for lifestyle choices "would constitute yet another marked extension of the common law."[149] However, it still concluded that "the change might never the less arguably be justified"[150] provided "it could be predicted with some certainty that all these negative effects of extending tort liability to the lifestyle choices of pregnant woman would in fact diminish the problem of injured infants."[151] In so doing, the Majority reverted to the original general principle and concluded that "the Court must approach the issue with great caution"[152] as the change would involve a host of complex ramifications that have "the potential to produce considerable uncertainty and affect many peoples' lives adversely."[153] Indeed, the Majority itself noted that the change would require an exception to the "born alive" rule. The fact that the Majority was not able to follow the rigid new principle it established for itself, and, ultimately reverted to the original principle requiring the Court to proceed with great caution, supports the view that the original rule concerning extension of the common law is more appropriate.

A significant shortcoming of the Majority judgment was that it failed to address the fundamental differences between the tort law which focuses on a breach of a duty of care, and the *parens patriae* jurisdiction which "exists for the stated purpose of doing what is necessary to protect the interest of those who are unable to protect themselves."[154]

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[149] *Ibid.* at para. 34.
[150] *Ibid.* at para. 43.
[151] *Ibid.*
[152] *Ibid.* at para. 34.
[153] *Ibid.* at para. 45.

Rather, the Majority declared that it rejected "extension of the court's *parens patriae* jurisdiction to permit protection of unborn children ...for reasons similar to those enunciated in connection with the submission that the law of tort should be extended to the unborn."[155] Whereas it is appropriate to extend the *parens patriae* jurisdiction to assist both mother and unborn child who are unable to help themselves because of the mother's bondage to addicting substances, it is not appropriate to make an addicted pregnant woman liable for breach of a duty of care to her unborn child resulting from a pattern of behavior over which she has no control.

The result of the Majority's application of the new principle as a bar to judicial extension of the tort law to provide legal protection for the unborn child from substance abuse during pregnancy was supportable. As explained in the Majority judgment:[156]

> While the law may properly impose responsibility for the consequences of addictive behavior, like drunkenness, the policy question remains of whether extending a duty of care in tort in this particular situation as the remedy for redressing problems which are caused by addiction is a wise option. Given the lack of control pregnant women have over many of these harmful behaviors, it is doubtful whether recognizing a duty of care to refrain from them will significantly affect their choices. As a result, the general deterrent value of the proposed new duty of care is questionable.

However, to reason that it is not appropriate to extend a duty of care to an addicted pregnant woman does not mean that an alternative pre-birth remedy should not be invoked. In fact, there would be a grotesque contradiction in our legal system to permit damages sustained as a "non person," but not provide a legal mechanism to prevent that damage from occurring. In the words of Justice Major:[157]

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[154] *Ibid.* at para. 103.

[155] *Ibid.* at para. 50.

[156] *Ibid.* at para. 41.

> It seems fundamentally unfair and inexplicable for this Court to hold that a foetus, upon live birth, can sue for damages to recompense injuries suffered *in utero*, yet have no ability to obtain a remedy preventing that damage from occurring in the first place. This is one of the clearest of cases where monetary damages are a singularly insufficient remedy. If our society is to protect the health and well-being of children, there must exist jurisdiction to order a pre-birth remedy preventing a mother from causing serious harm to her foetus.

The Majority decision concerning judicial extension of the common law is a dichotomy. On the one hand it urged judicial restraint and went so far as to change the general principle declared in *Watkins* so as to significantly reduce the scope of judicial discretion in matters involving major changes to the common law. On the other hand, the Majority overreached its jurisdiction by arbitrarily changing the general principle concerning extension of the common law without any explanation of its rationale for doing so. The key behind this ironic twist is the Majority's blatant frustration with the legislature's failure to address the need for legal protection for the unborn child. While this frustration is absolutely understandable, the Minority view is correct in law that the legislatures failure to do so "is not an excuse for the judiciary to follow the same course of inaction."[158]

The Majority's reliance on the "born alive" rule and the "slippery slope" argument as a bar to extension of the common law to provide legal protection of the unborn child was questionable. Similarly, its reference to women's right to freedom of choice was absurd when we recall that the Majority acknowledged that a product of addiction is the inability to control in-take of the substance being abused..."[159] Finally, its reasons were, in part, inconsistent with other Supreme Court of Canada precedents. For example, its

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[157] *Ibid.* at para. 140.

[158] *Ibid.* at para. 138.

[159] "Power and Procreation", *supra* note 136 at 53.

reasoning was not consistent with *Daigle*[160] where it was stated that the unborn child could be treated as a person only when it was necessary to do so to protect its interests after birth. Its reasoning was also inconsistent with *Montreal Tramways*[161] where the Supreme Court of Canada was compelled to extend the law of tort to apply to pre-birth injuries: if a right of action was denied, the child would be compelled to go through life "carrying the seal of another's fault ...without any compensation therefor."[162]

The common law must maintain its flexibility so that it may respond to the facts of each case. The original general principle that the Courts must proceed with great caution when extension of the common law involves major changes with complex ramifications must therefore be followed. Although extension of the Courts *parens patriae* jurisdiction is not an adequate response to the tragic epidemic of substance abuse during pregnancy, the Minority opinion established this approach to be justifiable from a legal perspective. Until such time that the political climate in Canada stabilizes to the point that the legislatures are able and willing to address the issue of addiction and substance abuse during pregnancy, it is essential that the Courts are able to call upon the adaptability of the common law. As Justice Majors observed, in cases involving chronic and severe substance abuse during pregnancy:[163]

> Where the harm is so great and the temporary remedy so slight, the law is compelled to act.

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[160] *Daigle, supra* note 92.

[161] *Montreal Tramways, supra* note 90.

[162] *Ibid.*

[163] *DFG, supra* note 1 at para. 138.

iv. THE FALL OF THE "SLIPPERY SLOPE"

The extreme nature of the facts illustrates why Justice Major was correct in both rejecting the "slippery slope" argument and declaring that it would be "derelict to suggest that we should not restrain this abuse because we can imagine some other cases that may not be as clear."[164] Furthermore, the Majority's reliance on the "slippery slope" argument illustrates the value of Justice Major's conclusion that "each case must be decided on its own facts"[165] and that the familiar "slippery slope" argument "cannot be raised as a principled bar to granting an injunction in this case."[166]

The Majority and Minority viewed the issues before the Court from widely divergent perspectives. The Majority broadly described the legal question before the Court:[167]

> ...the legal question remains: assuming that a mother is acting in a way which may harm her unborn child, does a judge, at the behest of the state, have the power to order the mother to be taken into custody for the purpose of rectifying her conduct?

Conversely, the Minority approached the Appeal from a narrow perspective, focusing on whether or not:[168]

> ...an order detaining a pregnant woman addicted to glue sniffing for which she has rejected an abortion and/or medical treatment and decided to carry her child to term, would require a change to the law which cannot be properly made other than by legislation.

The fact that the Majority framed the issue in terms of any conduct of a pregnant woman that may harm her unborn child is consistent with its heavy reliance on the "slippery slope" argument to justify its conclusion that the Court will not intervene where the changes are major and ramifications complex. Conversely, the Minority's focus on the facts of the case involving the detention of an addicted pregnant woman who had decided to carry the pregnancy to term was consistent with its conclusion that the "slippery slope" argument must not operate as a bar to judicial intervention in this case.

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[164] *Ibid.* at para. 122.
[165] *Ibid.* at para. 96.
[166] *Ibid.* at para. 127.
[167] *Ibid.* at para. 5.
[168] *Ibid.* at para. 60.

The Majority's reliance on the "slippery slope" argument may be traced to most of the issues which it addressed. It applied the "slippery slope" argument to justify its conclusion that the "born alive" rule was a bar to judicial intervention to prevent substance abuse during pregnancy. In this regard the Majority declared:[169]

> Having broken the time honored rule that legal rights accrue only upon live birth, the courts would find it difficult to limit application of the new principle to particular cases.

On the issue of whether or not the Court should recognize a cause of action for the lifestyle choices of pregnant women that may adversely affect the unborn child, the Majority was concerned that such suits would take the Courts into "the difficult policy issue of the extent to which the mother's lifestyle is actionable."[170] Its elaboration of this concern was rather dramatic:[171]

> Are children to be permitted to sue their parents for second-hand smoke inhaled around the family dinner table? Could any cohabitant bring such an action? Are children to be permitted to sue their parents for spanking causing psychological trauma or poor grades due to alcoholism or a parent's undue fondness for the office or the golf course? If we permit lifestyle actions, where do we draw the line?

Furthermore, its conclusion that each lifestyle "choice made by the woman in relation to her body will affect the fetus and potentially attract tort liability"[172] was overreaching.

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[169] *Ibid.* at para. 24.

[170] *Ibid.* at para. 33.

[171] *Ibid.*

[172] *Ibid.* at para. 37.

The Majority rejected the argument that:[173]

> ...the duty of care should be to refrain from activities that have no substantial value to a pregnant woman's well-being or right of self-determination and that have the potential to cause grave and irreparable harm to the child's life, health and ability to function after birth.

Rather, the Majority declared that these terms were too vague and broad to adequately confine the duty of care. The Majority acknowledged that "it may be easy to determine that abusing solvents does not add substantial value to a pregnant woman's well-being and may not be the type of self-determination that deserves protection."[174] However, because other behaviors are not as easily classified, it declared that "no bright lines emerge to distinguish tortious behavior from non-tortious once the door is opened to suing a pregnant mother for lifestyle choices adversely affecting the fetus."[175]

Overall, the Majority's application of the "slippery slope" argument was unpersuasive as it may be applied to any situation and thereby become an "*in terrorem* argument and lose whatever value it may legitimately possess."[176]

The Majority's reasoning to support its reliance on the slippery slope arguments may be criticized for several specific reasons. Most importantly, it was inappropriate for the Majority to apply arguments from the issue of tort law to the issue of extension of the *parens patriae* jurisdiction. As noted by the Minority:[177]

> The extension of the *parens patriae* doctrine in the case on appeal should not be viewed as an implicit sanctioning of a child's right to sue its mother for "lifestyle choices" made during pregnancy. A child initiating any action against its mother would have to prove, in this type of action as in others, all the necessary elements of a negligence claim, including causation and damages to the standard required in all tortious actions.

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[173] *Ibid.* at para 38.
[174] *Ibid.* at para. 39.
[175] *Ibid.*
[176] *Ibid.* at para. 127.
[177] *Ibid.* at para. 126.

Secondly, the Majority's criticism of the test of substantial value and well-being or right of self determination was particularly questionable in light of its reliance of the test in *Kamloops* v. *Nielson*[178] which could easily be described as too vague and broad as well. Finally, the Majority did not address the Minority's reasons for rejecting the "slippery slope" argument.

Justice Major consistently described the issue before the Court as being limited to "extreme"[179] circumstances where "no other reasonable means of treatment exists."[180] The decision was directed at the "abusive" conduct of a "reckless and/or addicted"[181] pregnant woman that has the potential to inflict "serious and permanent harm on a child she has decided to bring into this world."[182] While some may find it offensive that Justice Major implied that substance abuse during pregnancy was "serious abuse," the fact is that society, as reflected in provincial child welfare legislation, has accepted that such a determination is justifiable in rare and extreme cases. Furthermore, the fact that certain behavior may be considered abusive does not mean that the parent or pregnant woman is morally blameworthy. Rather, it is an indicator of the need for crisis intervention to assist parents to care for their children in narrowly defined and extreme cases of abuse. Indeed, this was the approach adopted by Justice Major. He declared that "the remedy of confinement must be for purposes of treatment and not punishment"[183] and that it should be at a "residential treatment facility or hospital which can offer a treatment program."[184]

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[178] *Ibid.* at para. 138.
[179] *Ibid.* at para. 121.
[180] *Ibid.* at para. 136.
[181] *Ibid.* at para. 95.
[182] *Ibid.*
[183] *Ibid.* at para. 125.
[184] *Ibid.*

Justice Major descrbed the minimum responsibility of a pregnant woman toward the unborn child she had chosen to bring into this world as being to "refrain from the abuse of substances that have, on proof to the civil standard, a reasonable probability of causing serious and irreparable damage to the foetus."[185] For example, "the failure of a pregnant woman to quit smoking or act in some way that is optimum for fetal health would not meet the test for state intervention."[186] Justice Major emphasized that the exercise of the *parens patriae* jurisdiction necessarily involved overriding some rights of the mother and therefore the standard for intervention must be "set at such a very high threshold."[187] Before the Court exercises its final option of confinement, it must be "certain on a balance of probabilities that no other solution is workable or effective."[188] In short, "the least rights-diminishing option should always be sought."[189]

Justice Major also focused on the fact that the temporary remedy of confinement was slight relative to the serious risk of life long harm to the unborn child. In fact, he endorsed the position of an American author who supported the view that "a state's compelling interest in potential life outweighs a mother's privacy right to conduct her life as she chooses when state intervention is hardly intrusive."[190] It may seem inconsistent to declare that the threshold for intervention is very high because liberty interests are at stake on the one hand, and on the other imply that the intervention is hardly intrusive. The fact is however, in the context of the entire judgment, it was not. What was being argued was that mandatory treatment for substance abuse during pregnancy for rehabilitative purposes, and not for punishment, is not intrusive relative to invasive intervention that may conflict with the best interests of the mother. The fact that Ms. G. voluntarily remained in treatment after the order for detention was stayed supports this argument, as does the Majority judgment where it was acknowledged that people do not want to be drug addicts but are simply unable to "control in-take of the substance being abused..."[191]

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[185] *Ibid.* at para. 116.
[186] *Ibid.* at para. 127.
[187] *Ibid.* at para. 124.
[188] *Ibid.*
[189] *Ibid.*
[190] *Ibid.* at para. 131 where Justice Major cites C.A. Kyres, "A 'Cracked' Image of My Mother/Myself? The Need for a Legislative Directive Proscribing Maternal Drug Abuse" (1991) 25 New Eng. L. Rev. 1325 at 1350 [hereinafter "Cracked Image of Mother"] .

v. THE "BORN ALIVE" RULE CHALLENGED

The Majority's affirmation of the "general proposition that the law of Canada does not recognize the unborn child as a legal or juridical person"[192] was overreaching, oversimplified and based on "blind imitation of the past."[193] It simply reasoned that the Supreme Court of Canada's decisions that the unborn child is not a person firstly, for the purposes of the *Civil Code of Lower Canada* and the *Quebec Charter* and secondly, for the purposes of the *Criminal Code*, applied similarly to the status of the foetus at common law.[194] Given the tremendous controversy associated with this conclusion, a thorough explanation of the reasons for this conclusion was indicated. Particularly in view of Justice Major's thorough and convincing dissenting opinion on this issue.

The Majority's reliance on the "born alive" rule, without any inquiry into the genesis or purpose of the rule, was particularly inadequate when examined in the context of the Minority opinion which established the rule to be an evidentiary presumption that is outdated and indefensible now that:[195]

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[191] *Ibid.* at para. 41.

[192] *Ibid.* at para. 11.

[193] O. W. Holmes, "The Path of the Law" (1897), 10 Harv. L. Rev. 457 at 469. This quote was cited by the Majority at para. 110.

[194] *Ibid.* at para. 15.

> technologies like real time ultrasound, fetal heart monitors and fetoscopy clearly show that a foetus is alive and has been or will be injured by conduct of another.

Furthermore, the Majority failed to address the fact that its affirmation of the general proposition that Canada does not recognize the unborn child as a juridical person is inconsistent with the Supreme Court of Canada decision in *Daigle*. As noted by Justice Major:[196]

> Protecting the unborn child from having to live its life suffering from severe mental and physical disabilities should meet the test of necessity "to protect its interests after it is born."

The Majority also failed to address its own precedent in *Montreal Tramways* where a particularly relevant factor in the Supreme Court of Canada's decision to change the common law and allow an action for prenatal injuries was the fact that the law at the time did not provide a remedy. In this regard the Court in *Montreal Tramways* declared:[197]

> If a child after birth has no right of action for prenatal injuries, we have a wrong inflicted for which there is no remedy...If a right of action be denied to the child it will be compelled without any fault on its part, to go through life carrying the seal of anther's fault and carry a very heavy burden of infirmity and inconvenience without any compensation therefore.

The Majority did not address this authoritative precedent declared in *Montreal Tramways* but simply responded that "It is not every evil which attracts court action- some evils remain for the legislature to correct."[198] While the Majority was correct in its conclusion that substance abuse during pregnancy is an "evil" that should be corrected by the legislature, this fact does not account for its failure to properly examine the relevance of the "born alive" rule at common law today.

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[195] *Ibid.* at para. 109.

[196] *Ibid.* at para. 117.

[197] *Montreal Tramways, supra* note 90 at 460.

[198] *DFG, supra* note 1 at para. 26.

The Majority should have addressed the issue of the legal status of the unborn in a similar manner to that observed by Professors Litman and Robertson in their study for the Commission:[199]

> The issue has arisen in a number of different legal contexts and has tended to be addressed on an ad hoc basis. As one would expect, particularly in an area as sensitive as this, the courts have often been influenced by policy factors, the nature of these factors varying with the particular context in which the issue has arisen. It is clear that Canadian courts have been unwilling to regard a fetus or embryo as a person. They have done so only in very limited circumstances and for limited purposes.

This approach is consistent with the Supreme Court of Canada's declaration in *Daigle* that the unborn child is only treated as a person when it is necessary to do so to protect its interests after it is born. It is also consistent with the Minority view that:[200]

> Protecting the unborn child from having to live its life suffering from severe mental and physical disabilities should meet the test of necessity 'to protect its interests after it is born.'

The Majority's brief reasons for not overturning the rule that legal rights accrue only at birth were inadequate. It referred to the Australian decision in *Watt* v. *Rama*[201] where the Supreme Court of Victoria, in permitting a claim for prenatal injury, purported to explain why the right to sue does not exist prior to birth. However, all that *Watt* actually said was that "on birth the relationship crystallized and out of it came a duty in relation to the child."[202] It is the "very nature of things" that the child could not acquire rights correlative of a duty until it became a living person.[203] Based on this "rationale," the Majority reasoned that extension of the common law to recognize a duty of care owed to the fetus would constitute a major departure from the common law as it had stood for decades. The fact is, however, that this "rationale" is simply blind adherence to the past rather than a reasonable explanation for the rule. The Majority seemed to overlook that it is precisely because of the rule that the unborn child is not considered a juridical person. Furthermore, the Majority did not address a particularly relevant discussion in *Watt* where the judge rejected the argument of the defense that a two-month fetus is merely part of her mother and, therefore, is not entitled to legal protection. Rather, the judge concluded that because there was essentially no difference between the unborn child and a newborn child they should be similarly protected:[204]

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[199] M. Litman and G. Robertson, "Is a Property Law Regime Appropriate?" in Research Studies of the Royal Commission on New Reproductive Technologies, *Overview of legal Issues in New Reproductive Technologies*, vol. 3 (Ottawa: Minister of Supply and Services Canada, 1993) 233 at 235.

[200] *DFG, supra* note 1 at para. 117.

[201] [1972] V.R. 353.

[202] *Ibid.* at 360-361.

> As its property, real or personal, is protected, so should its physical substance be similarly protected by deeming it to be a person in being and imposing a duty of care on any other person not to commit any act of carelessness which as a reasonable man he should anticipate would injure the physical substance of the unborn child.

The Majority dismissed the argument that there is little difference between the unborn child and a new born child on the basis that the argument relates to a biological inquiry, and the inquiry before the Court was a legal one. This approach raises the question of what is the appropriate approach to issues arising from disagreement about whether the fetus is a human being. History illustrates the grave injustices that have occurred by excluding certain classes of human beings from the human family including Jews, blacks, "witches" and women. The atrocities committed by this practice compels us to frame our definition of who belongs to the human family widely enough so as to avoid excluding members, or future members of society; even if a particular class of persons or potential persons is not in public or political favor at a particular time. Times change as exemplified by the world-wide regret, shame and anger that is felt when we look back on the violations of fundamental human rights that have been committed by employing the justification that particular classes of people are not human beings. In this regard, the following reasoning of Lord Sankey of the Privy Council in its decision to overturn the infamous decision of the Supreme Court of Canada in the celebrated *Person's* case is relevant:[205]

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[203] *Ibid.*

[204] *Ibid.*

> The word "person" may include members of both sexes, and to those who ask why the word should include females, the obvious answer is why not? In these circumstances the burden is upon those who deny that the word includes women to make out their case.

Applying this line of reasoning to *DFG,* it is clear that the Majority's application of the "born alive" rule to deny legal status of the unborn child that would be carried to term was not sufficient to make its case in light of the compelling logic of the Minority decision.

The Minority, on the other hand, thoroughly and logically examined the history of the "born alive" rule to illustrate why the rule should not apply in this case. The purpose of the rule was first examined. It was noted that until the early 19th century, it could not be determined prior to quickening whether a woman was pregnant or whether the child *in utero* was alive. Furthermore, it could not be determined whether a child *in utero* was alive at the time it was subjected to an injury unless the child was also born alive suffering from that injury. In short, the Minority's reasons supported the conclusion that "live birth was required to prove that the unborn child was alive and that the material acts were the proximate cause of death."[206]

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[205] *Edwards, supra* note 96 at 138. Justice Major cited this case to support his argument at para. 118 that: "Rigidly applying precedents of questionable applicability without inquiry will lead the law to recommit the errors of the past."

The Minority also examined how practical application of the "born alive" rule demonstrated that the rule was "was an evidentiary and not a substantive moral definition of a human being at common law."[207] This argument essentially came down to the fact that:[208]

> If the rule was truly a substantive definition of human being, and a fetus only became a human being at birth, then injuring an unborn child *in utero* would not be injuring a human being.

In concluding that it was no great step for the Court to conclude that the "born alive" rule was not applicable in this case, the Minority emphasized that the matter at hand involved purely the common law, and that no enactment of Parliament prevented a re-evaluation of the rule. The Minority also referred to the fact that Canadian Courts have already recognized the need to re-evaluate the rule in view of advances in medical technology.[209]

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[206] Legal Anachronisms, *supra* note 86 at 575.

[207] *Ibid.* at 589.

[208] *Ibid.*

[209] *DFG, supra* note 1 at para. 114. Justice Major also noted at para. 111 that "some states, armed with today's medical knowledge have stepped forward and distinguished the rule." He cited *State* v. *Horne*, 319 S.E. 2d 703 (1984) as a precedent to illustrate that some states, for the purposes of homicide statutes, have abandoned the "born alive" rule. This case was also cited in the decision of Justice Toal in *Whitner* v. *The State*, 492 S.E. 2D 777 (1997) to support the conclusion that:

> ... it would be absurd to recognize the viable fetus as a person for the purposes of homicide laws and wrongful death statutes but not for purposes of statutes proscribing child abuse.

The U.S. Supreme Court in *Whitner* v. *South Carolina*, 118 S.Ct. 1857 (1998) recentlyl refused a petition for *certiorari* of the decision of Justice Toal. In that case Cornelia Whitner was charged with criminal child neglect for causing her baby to be born with cocaine metabolites in its system, even though the legislation in issue did not define "child" to include "viable fetus." For a further discussion of this case please refer to pages 31-36 of chapter two.

The significant human rights implications of the "born alive" rule and its contribution to the overused, misunderstood and often misguided argument that the unborn child is not a person must not be underestimated. It is clear that many people believe that the rule is a moral definition of a human being. Many others accept the entirely unjustified assertion that even Parliament, or provincial legislatures, cannot legislate to protect the unborn child as it is not a person. Fortunately, in the wake of *DFG,* there is now a strong foundation on which to dispel these misconceptions. Whether one adopts the Majority view that the "born alive" rule with respect to substance abuse during pregnancy is an "evil" that should be corrected by the legislature, or whether one adopts the Minority view that the rule should not be applied for the purposes of this case, it is obvious that the legislatures must critically examine the rule pursuant to a thorough process of law reform.

vi. "FREEDOM OF CHOICE" ?

The Majority and Minority had very different views concerning the issue of freedom of choice and individual autonomy. The Majority was inconsistent in its examination of these issues and improperly applied the "slippery slope" argument to conclude that the proposed changes to the common law would "involve moral choices and would create conflicts between fundamental interests and rights"[210] that would have an "immediate and drastic impact on the lives of women...."[211] The Minority analysis, on the other hand, was balanced and limited to the facts of the case. This brief comparative analysis of these divergent approaches to the issue of women's right to autonomy and freedom of choice highlights the value the Minority's application of the fundamental principle that freedom of choice and individual autonomy are not absolute. Rights generally have corresponding responsibilities. Arguments based on freedom of choice can only be evaluated in the context of the framework of rights in which it is asserted.

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[210] *Ibid. at* para. 24.

[211] *Ibid.*

A significant factor in the Majority's decision that the common law should not be extended to permit the trial Court's orders for detention was the Commission's view that "recognizing a duty of care owed by a mother to her child for negligent prenatal behavior may create a conflict between the pregnant woman as an autonomous decision maker and her fetus." [212] The Majority declared that "to make orders protecting fetuses would radically impinge on the fundamental liberties of the pregnant woman, both as to lifestyle choices and how and as to where she chooses to live and be."[213] It is ironic that the Majority came to this conclusion when, elsewhere in its decision, it referred to the fact that women suffering from chronic and severe addiction lack control over this harmful behavior and that alcohol consumption and drug abuse is often more a "product of circumstance and illness than freedom of choice."[214] This inconsistency devalues the Majority argument that the common law should not be extended as proposed because it is an unreasonable infringement on women's freedom of choice. Where is the infringement on freedom of choice in light of the Majority's affirmation of the fact that "people do not want to be drug addicts"[215] and that people suffering from severe addiction lack control over the addictive behavior?

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[212] Report, *supra* note 112 at 957-958.

[213] *DFG, supra* note 1 at para. 55.

[214] *Ibid.* at para. 41.

In support of the conclusion that orders protecting fetuses would improperly impinge on the fundamental liberties of the pregnant women, the Majority referred to the inseparability of the fetus from the mother and declared that the "pregnant woman and her unborn child are one."[216] This observation is commonly asserted, particularly in the context of the abortion debate, to support the view that the unborn child cannot have rights separate from his or her own mother. However, in cases when the child will be born, this line of reasoning must be evaluated in the context of the risk of serious and permanent damage to the unborn child who will become an individual in his or her own right. Furthermore, the logic behind the view that the unborn child cannot have rights separate from its mother should be re-examined in the context of this somewhat chilling analogy:[217]

> ...ignoring the fetus because another being has power over it is eerily reminiscent of arguments used to deny the personhood of women on the basis of the husband's right to control his own wife -the two being 'one flesh.'

In its reasons for disagreeing with the Majority and concluding that the *parens patriae* jurisdiction should be extended, the Minority acknowledged that its ability to intervene was limited because people generally have a right to choose their own lifestyle. However, the Minority properly balanced the right to choose one's own lifestyle with the "fundamental precept of our society and justice system that society can restrict an individual's right to autonomy where the exercise of that right causes harm to others."[218]

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[215] *Ibid.* at para. 41 where Justice McLaughlin quoted "Power and Procreation", *supra* note 136 at 53.

[216] *Ibid.* at para. 55.

[217] I. T. Benson, "What's Wrong With 'Choice,'" in Ian Gentles ed., *A Time To Choose Life* (Toronto: Stoddart Publishing Company, 1990) 24 at 39 [hereinafter "What's Wrong With Choice"].

[218] *DFG, supra* note 1 at para. 131.

In so doing, the Minority declared that conversely:[219]

> ... it would be unjust not to restrict one person's right of autonomy when the exercise of that right causes harm to others.

Dr. Scorsone's dissenting opinion in the Report was quoted by the Minority to support this line of reasoning. It emphasized that "rights necessarily entail responsibility"[220] and that if our choices harm others they must be limited, "whatever our gender."[221] It also stated that "autonomy is a necessary good, but it is not absolute."[222]

Dr. Scorsone's position quoted by the Minority in *DFG* is consistent with an article which she published several years prior to the Report which examined the abortion issue on the basis that the debate was really about "two partially opposed applications of one single principle - that of freedom."[223] She viewed both sides of the abortion debate as being deeply committed to freedom of the individual. However, they were divided on whose freedom should have priority - mother or child?

Dr. Scorsone noted that "the conviction that personal liberty is essential"[224] is a principle held by virtually everyone in the country. Unfortunately however, the ideal of freedom has changed over the centuries. It has retained the "fervor which fired earlier generations and made it compelling"[225] but it has become detached from responsibility for others. It is, therefore, enlightening that the Minority was sensitive to this fact and developed a balanced perspective of a woman's right to abuse substances during pregnancy; a perspective that implied that it would be unjust and irresponsible not to prevent this behavior because of the high risk of serious and permanent damage to future members of our society.

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[219] *Ibid.*

[220] *Ibid.* where Justice Major quoted the Report, *supra* note 113 at 1131.

[221] *Ibid.*

[222] *Ibid.*

[223] S. Scorsone, "Freedom: Choice or Life?" in I. Gentles ed., *A Time To Choose Life* (Toronto: Stoddart Publishing Company, 1990) at 19.

[224] *Ibid.*

[225] *Ibid. at* 20.

The Minority was correct to evaluate the "freedom of choice" issue in the context of the facts of the case. Choice itself is morally neutral and can only be evaluated as right or wrong in terms of the rights that are in conflict.[226] This evaluation was properly undertaken in the Minority opinion as indicated by its declaration that:[227]

> Having chosen to bring a life into this world, that woman must accept some responsibility for its well-being. In my view, that responsibility entails, at the least, the requirement that the pregnant woman refrain from the abuse of substances that have, on proof to the civil standard, a reasonable probability of causing serious and irreparable damage to the foetus.

Professor Glendon illustrated the destructive influence of the new rhetoric of rights talk, defined in part by its exaggerated absoluteness, "a near-silence concerning responsibility, and tendency to envision the rights-bearer as a lone autonomous individual"[228] with this example:[229]

> ...those who contest the legitimacy of mandatory automobile seat-belt or motorcyle-helmet laws frequently say: 'It's my body and I have the right to do as I please with it.' ...The implication is that no one else is affected by my exercise of the individual right in question. This way of thinking and speaking ignores the fact that it is a rare driver, passenger, or biker who does not have a child, or a spouse, or a parent. It glosses over the likelihood that if the rights-bearer comes to grief, the cost of his medical treatment, or rehabilitation, or long term care will be spread among many others. The independent individualist, helmetless and free on the open road, becomes the most dependent of individuals in the spinal injury ward. In the face of such facts, why does our rhetoric of rights so often shut out relationship and responsibility,

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[226] For a discussion of this concept see; What's Wrong With Choice, *supra* note 215 at 25-27.

[227] *DFG, supra* note 1 at para. 116.

[228] *Rights Talk, supra* note 115 at 45.

[229] *DFG, supra* note 1 at para. 24.

along with reality?

And so it is with the chronic and severe substance abuser. The ravages of addiction make him or her vulnerable to crime, abuse, poverty, family breakdown, isolation and severe life threatening-illness. Not only do these individuals suffering from addiction often become the most dependent members of society, but so do their offspring because of the harm caused directly by prenatal substance abuse, or because they too develop addiction problems as a result of the intergenerational nature of addiction. In the face of these harsh realities, the Courts, policy-makers and scholars must critically examine women's right to reproductive autonomy in the context of substance abuse during pregnancy.

vii. THE ABORTION CONTROVERSY REARS ITS UGLY HEAD

The Majority and Minority decisions both highlighted the fact that the issue of substance abuse during pregnancy is fundamentally connected to the raging abortion controversy. The large number of abortion interest groups that obtained intervenor status in this appeal reflects the stakeholders perception that its outcome will influence the debate. The Majority validated this concern in its declaration that if the unborn child is a legal person with legal rights, arguments can be made in favor of the proposition that women who choose to terminate a pregnancy may "face injunctive relief prohibiting termination."[230] Furthermore, the Majority concluded that substance abuse during pregnancy should be left to the legislature to address because the proposed changes may be counterproductive in that they may "persuade women who would otherwise choose to continue their pregnancies to undergo an abortion"[231] because of the threat of being without their addicting substance.

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[230] *Ibid.*

The Minority viewed the abortion issue from an entirely different perspective. It declared that nothing in its reasons for deciding to extend the *parens patriae* jurisdiction would interfere with the effect of the *Morgentaler* decision which "struck down this country's criminal prohibitions against abortion."[232] Whereas the Majority viewed the prospect that orders for mandatory treatment may encourage a pregnant woman to elect to terminate her pregnancy as an important reason for not extending the common law, the Minority reasoned that a woman's option to choose an abortion, was in part, justification for judicial intervention. In this regard the Minority declared:[233]

> The mother's continuing ability to elect an abortion and end her confinement makes the intrusion of her liberty relatively modest when weighed against the child from birth being seriously and permanently impaired.

The Minority reinforced this position throughout the decision by continually noting that the pregnant woman, mandated for treatment pursuant to the Courts exercise of its *parens patriae* jurisdiction, would be free to end her confinement by terminating her pregnancy.

The conflicting views between the Majority and the Minority regarding the appropriate significance of the abortion issue raises several questions. Would the proposed extension of the *parens patriae* jurisdiction interfere with women's "right" to choose to terminate a pregnancy? Is the possibility that the judicial intervention may encourage women to terminate their pregnancy a valid reason for not granting the proposed relief? Is it inconsistent to "to place restraints upon a woman's abusive behavior towards her foetus that she has decided to carry to term yet continue to preserve her ability to choose abortion at any time during her pregnancy"?[234] How should a woman's decision to carry a child to term be determined?

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[231] *Ibid.* at para. 44.

[232] *Ibid.* at para. 116.

[233] *Ibid.* at para. 133.

Superficially, the Majority's suggestion that overturning the "born alive" rule would expose pregnant women to the risk of injunctive relief prohibiting abortion seems logical. However, the Minority addressed this concern by declaring that the "rationale of protecting the child/foetus by the exercise of the *parens patriae* jurisdiction ...depends on the intention of the mother to carry the child to term." [235] This distinction relied on by the Minority between abortion cases and the case at hand where the mother has decided to carry the pregnancy to term is consistent with the decision of Supreme Court of Canada in *Tremblay* v. *Daigle* where it was declared that:[236]

> A foetus is treated as a person only where it is necessary to do so in order to protect its interests after it is born.

However, the challenging aspect of this distincition is that it involves the complexity of a pregnant woman's "decision" of whether or not to carry her pregnancy to term. The Majority addressed this issue by declaring that:[237]

> It is not a question of a woman making a "declaration" of her intention. Rather, the law will presume that she intends to carry the child to term until such time as she indicates a desire to recieve, makes arrangements for or obtains an abortion.

There is no doubt that Justice Major's approach to this complex issue is debateable.[238] However, on the facts of the case at hand, abortion was not an issue.

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[234] *Ibid.* at para. 116.
[235] *Ibid.* at para. 117.
[236] *Daigle, supra* note 92 at 563.
[237] *DFG, supra* note 1 at para. 117.
[238] Justice Schulman was apparently sensitive to the complexity of a woman's

It is ironic that the Majority, in its decision not to extend the common law to provide protection for the unborn child, viewed abortion in a negative light. Conversely, the Minority reasoned that a women's continuous option to have an abortion was consistent with and supported its decision to extend the *parens patriae* jurisdiction. The Majority concluded that it was unacceptable that orders made for protection of the unborn child might result in its destruction. On the other hand, the Minority implicitly condoned a mother's election to have an abortion. Both the Majority and Minority positions are tremendously controversial from both a "pro-life" and a "pro-choice" perspective in that the Majority position arguably implies that abortion is wrong, whereas the Minority position implies that abortion is preferable to a life of suffering. Fortunately, this controversy is not particularly relevant to the issue of judicial extension of the *parens patriae* jurisdiction in this case. There was no empirical evidence to suggest that the proposed orders would in fact persuade pregnant women to elect to terminate their pregnancies. Furthermore, abortion was not an issue in the case at hand. On the facts of this case, Justice Major's conclusion makes perfect sense that once a woman decides "to bring a life into this world, that woman must accept some responsibility for its well being."[239] Even more importantly, society must take responsibility for identifying, preventing and treating the root causes of addiction, substance abuse during pregnancy, and unwanted pregnancies. Upon this foundation, comprehensive legislation may be

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"decision" to carry the pregnancy to term. In *obiter,* he remarked that the fundamental issue to be determined when addressing the question of extension of the *parens patriae* jurisdiction to the unborn child would "be to determine, on a reasonable basis, that the child will indeed be born. This will depend on the evidence which will include evaluating the intention of the mother." *DFG, supra* note 1 at para. 45 cited to M.J. No. 386 (QL).

[239] *DFG, supra* note 1 at para. 116.

developed based on "serious and sustained political discussion"[240] so that compromises may be reached that will help overcome the social problems resulting in tragedies like those suffered by Ms. G. and her children.

The Minority's justification for the apparent inconsistency of condoning abortion and yet extending the common law to provide legal protection for the unborn child from substance abuse during pregnancy is twofold. First, Justice Major endorsed the position of American author, Kyres,[241] who argued that the state's interest in potential life becomes compelling when state intervention is "hardly intrusive." The privacy right of pregnant women protecting their daily conduct is far weaker then her right to decide to have an abortion, as in his view, "although it might not always be in her interest to have a child, it is never in her interest to have a child with birth defects."[242] Second, it reasoned that both abortion and the proposed intervention prevent unnecessary spending by Canadian governments to permanently care for the mentally disabled child born as a result of the mother's unrestricted drug addiction.[243] The Minority position is consistent with that adopted by Dr. Keyserlingk. He argued that the unborn child should be legally protected from a mother's behavior that involves a serious risk of resulting disability. However, he also argued that the unborn child 's rights end when the mother decides to have an abortion.[244]

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[240] *Rights Talk, supra* note 115 at x.

[241] "Cracked Image of Mother" *supra* note 190 at 1350.

[242] *Ibid.*

[243] *DFG, supra* note 1 at para. 141.

[244] Dr. E. Keyserlingk, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective* (Montreal: Quebec Centre of Private and Comparative Law, 1984).

viii. CONCLUSION

While the Majority ruling that the legislature must address substance abuse during pregnancy is virtually indisputable, it does not follow that the Minority was incorrect in its conclusion that the *parens patriae* jurisdiction over minors should be extended to provide legal protection of the unborn child from substance abuse during pregnancy in this case. On the contrary, the Minority judgment presented many compelling arguments that were not adequately answered by the Majority. Advancements in medical technology have rendered the "born alive" rule indefensible, particularly in cases where the child will be born. It is derelict to apply the "slippery slope" argument to conclude that chronic and severe substance abuse during pregnancy should not be restrained because some cases of "abuse" may not be as clear. Freedom of choice is not absolute. When a woman chooses to carry a child to term, blatantly destructive behavior may be properly restrained. It is extremely disappointing that the arguments developed by the Minority, which required so much, were given so little logical examination by the Majority. Perhaps the Majority simply was not equipped nor willing to rise to the challenge, both from a legal and political perspective.

The essence of Justice Major's reasons for concluding that legislative inaction is not an excuse for the judiciary to follow the same course of inaction may be distilled from the following line of reasoning. At the commencement of the Minority decision, Justice Major declared that "the state has an enforceable interest in ensuring, to the extent practicable, the well-being of the unborn child and the appeal should be allowed."[245] Justice Major later argued that to permit the "slippery slope" argument as a bar to judicial intervention would be to endorse an approach that would "entail the state to stand idly by while a reckless and/or addicted mother inflicts serious and permanent harm on to a child she had decided to bring into this world."[246] In the context of this argument, Justice Major posed this compelling question:[247]

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[245] *DFG, supra* note 1 at para. 66.

> Society does not simply sit by and allow a mother to abuse her child after birth. How then should serious abuse be allowed to occur before the child is born?

In short, Justice Major's conclusion that legislative inaction is not an excuse for the judiciary to follow the same course of inaction is based on the fundamental concept that the states "enforceable interest in ensuring, to the extent practicable, the well-being of the unborn child"[248] compels it to intervene to prevent an addicted or reckless pregnant woman from unintentionally inflicting permanent and life-long harm on a future member of society.

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[246] *Ibid.* at para. 95.

[247] *Ibid.* at para. 103.

[248] *Ibid.* at para. 66.

CHAPTER FOUR
REPORT OF THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

I. INTRODUCTION

This critical analysis challenges the recommendations of the Royal Commission on New Reproductive Technologies (hereinafter the "Commission") to absolutely prohibit judicial intervention during pregnancy. The author agrees with the Commission's conclusion that, in the vast majority of cases, what is required to address the problem of prenatal drug abuse is "ready access to facilities and services that provide outreach, counselling, and treatment designed specifically for women that are appropriate to their needs."[1] However, the Commission failed to adequately consider the potential value of mandatory treatment for chronic and severe substance abuse during pregnancy. Particularly in view of the widespread availability of civil commitment procedures for drug addiction in many countries around the world.[2] Indeed, civil commitment for drug addiction is consistent with the authorities on addiction that have concluded; "the fact is that many addicts do not enter the treatment system unless they are forced to do so."[3] Furthermore, the Commission's legal and ethical reasoning failed to justify the absolute and final nature of the recommendations. It relied upon debatable and over simplified legal and ethical arguments- primarily based on its view of women's right to reproductive autonomy and equality. It is clearly inappropriate to recommend a prohibition of mandatory treatment at a time when the threat of Aids has encouraged further examination of civil commitment practices directed toward intravenous drug users in some parts of the world. The fact that the "IV drug user has been viewed as most largely responsible for cases of pediatric aids"[4] must not be overlooked.

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[1] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) 949 at 963-64 [hereinafter "Report"]. Dr. Scorsone's dissenting view is presented at p. 1123-43 of vol. 2 of the Report.

[2] B. Brown, "Civil Commitment-An International Perspective" (1988) 18 (4) "The Journal of Drug Issues" 663 at 671 [hereinafter "Brown"].

[3] J. Platt et. al., "The Prospects and Limitations of Compulsory Treatment for Drug Addiction" (1988) 18 (4) The Journal of Drug Issues 505 at 511 [hereinafter "Platt"].

Critical analysis of the recommendations to prohibit judicial intervention during pregnancy is achieved by measuring the Commission's legal and ethical reasoning against its framework for decision making; the ethic of care and guiding principles. Inadequacies in the Commission's reasons are highlighted by challenging the view presented by the Commission to opposing authorities, and in particular the dissenting opinion of Dr. Scorsone. Indeed, the author ultimately adopts Dr. Scorsone's conclusions regarding the many complex issues raised by judicial intervention during pregnancy that:[5]

> ... there has not been sufficient reflection on them, by Canadian society as a whole or by the expert disciplines, to warrant any categorical statements by this Commission on the most humane and constitutionally consistent approach.

The author also adopts Dr. Scorsone's view that, while, the arguments raised by the Commission are politically potent today, they raise serious questions as to whether:[6]

> ...there are not other, still greater evils which arise if we hold that a woman must not or cannot ever, in principle, have her autonomy (reproductive) limited.

The negative implications of "rights talk"[7] on the Commission's recommendations are highlighted throughout the chapter. It obstructed the "serious and sustained political discussion" which is necessary for an effective evaluation of the potential of mandatory treatment for prenatal substance abuse to promote the best interests of women and children in rare and extreme cases.

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[4] Brown, *supra* note 2 at 675.

[5] Report, *supra* note 1 at 1124.

[6] *Ibid.*

[7] M. A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: The Free Press, 1991) [hereinafter *Rights Talk*].

II. THE ROYAL COMMISSION ON NEW REPRODUCTIVE TECHNOLOGIES

The Commission was created in 1989[8] as a result of the lobbying efforts of a nation-wide coalition of women's organizations, health organizations and others.[9] The Commission reported on November 15, 1993. The financial cost for completion of its mandate was $25 million.[10]

The mandate of the Commission, which has been described as the broadest of any similar commission in any country, was to:[11]

> ... inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied...

The Commission's mandate included the specific direction to examine "judicial interventions during gestation and birth"[12] which is the focus of this chapter. The breadth of the Commission's mandate is illustrated by the fact that its mandate concerning judicial intervention during pregnancy, practically speaking, does not concern new reproductive technologies. As indicated in the Report, to date, judicial intervention during pregnancy has primarily involved enforced Cesareans, enforced blood transfusions and intervention to prevent substance abuse during pregnancy.[13] These circumstances do not involve new reproductive technologies as they are understood today. Although the mandate potentially applies to situations that involve new reproductive technologies such as fetal *intra utero* surgery and fetal *intra utero* drug therapy, judicial intervention in such circumstances today is merely hypothetical.

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[8] The Commission was created by Order-in-Council P.C. 1989-2150.

[9] For a detailed listing of the organizations see M. Eichler, "Frankenstein Meets Kafka: The Royal Commission on New Reproductive Technologies" in G. Bassen, M. Eichler & A. Lippman. eds., *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies,* vol. 1 (Hull, Que.: Voyageur, 1993) 196 [hereinafter "Eichler"].

[10] *Ibid.*

[11] Report, *supra* note 1 at 2. P.C. 1989-2150 was reproduced in part in the Report.

[12] *Ibid.* at 951.

As noted in chapter two, this chapter highlights the fact that it is inappropriate to lump together all potential instances of judicial intervention during pregnancy under the same research processes and resulting recommendations. While the recommendations made by the Commission may be appropriate for circumstances actually involving new reproductive technologies such as fetal *intra utero* surgery and fetal *intra utero* drug therapy, they are not appropriate to address the problem of substance abuse during pregnancy.

III. THE RECOMMENDATIONS

The Commission concluded that judicial intervention during gestation and birth was neither an acceptable nor an effective method of maximizing the chances for the birth of a healthy child. It, therefore, recommended that:[14]

> 273. Judicial intervention in pregnancy and birth not be permissible. Specifically, the Commission recommends that
>
> (a) medical treatment never be imposed upon a pregnant woman against her wishes;
> (b) the criminal law, or any other law, never be used to confine or imprison a pregnant woman in the interests of her fetus;

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[13] *Ibid.*
[14] *Ibid.* at 964.

(c) the conduct of a pregnant woman in relation to her fetus not be criminalized;
(d) child welfare or other legislation never be used to control a woman's behavior during pregnancy or birth; and
(e) civil liability never be imposed upon a woman for harm done to her fetus during pregnancy.

274. Unwanted medical treatment and other interferences, or threatened interferences with the physical autonomy of pregnant women be recognized explicitly under the *Criminal Code* as criminal assault.

and that

275. All provinces/territories ensure that they have in place
(a) information and education programs directed to pregnant women so that they do not inadvertently put a fetus at risk;
(b) outreach and culturally appropriate support services for pregnant women and young women in potentially vulnerable groups; and
(c) counselling, rehabilitation, outreach, and support services designed specifically to meet the needs of pregnant women with drug/alcohol addictions.

Dr. Scorsone agreed with the "vast majority of the recommendations"[15] of the Commission. She offered only six dissenting opinions, one of which concerned judicial intervention during pregnancy and birth. In this regard Dr. Scorsone stated:[16]

> I do not concur with the recommendation that judicial intervention in pregnancy not be permissible, nor do I concur with the associated legislative measures. Words like "never" are, in my view, far too absolute. Intervention is generally inadvisable, but should not be entirely precluded. The existing possibility of recourse to the courts, a disinterested forum with accepted legitimacy for mediation and resolution of conflict in matters of human welfare, remains necessary in an area so fraught with ambivalence on the part of all parties in very specific and particular personal difficulties.

IV. CRITICISM

The Commission has been criticized for its flawed public participation process, internal structure and research processes. A brief over view of the extreme nature of these concerns provides useful background information for critical analysis of the recommendations to prohibit judicial intervention during pregnancy. The major problems in this regard may be summarized as follows:[17]

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[15] *Ibid.* at 1053.

[16] *Ibid.* at 1041.

> * an undemocratic internal structure was established by the Chair, which prevented Commissioners from participating meaningfully in discharging their duties and which resulted in anomic staff relations;
>
> * a manipulative public participation process was instituted which gave the appearance of public participation while precluding genuine participation on the part of many;
>
> * the research process was cloaked in secrecy and rigidly controlled. The Chair treated the research as her unilateral responsibility, rather than that of the Commission as a whole- while failing to maintain the normal standards of Canadian social science research.

i. UNDEMOCRATIC COMPOSITION

Eichler described extraordinary background information to illustrate her reasons for concluding that the Commission had a profoundly undemocratic composition.[18] The most dramatic example relates to a law suit filed against the Chair of the Commission and the federal government by four of the seven originally appointed Commissioners.[19] The purpose of the suit was to overturn, as contrary to the Public Inquiries Act, the second Order-in-Council which appointed two new Commissioners well after the research had commenced. The Order granted exclusive decision-making authority to the Chair and was described by Eichler as unprecedented:[20]

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[17] Eichler, *supra* note 9 at 197.

[18] *Ibid.*

[19] *Ibid.* The Statement of Claim is reprinted at 273. The style of cause is: *Martin Hebert, Loise Vandelca, Bruce Hatfield and Maureen McTeer* v. *Her Majesty the Queen in Right of Canada, The Attorney General of Canada, and Patricia Baird.* The Statement of Claim was filed on December 6, 1991.

[20] *Ibid.* at 200.

> The government's unusual decision to appoint two additional Commissioners so late in the life of the Commission effectively disempowered the original majority. No change in the exclusive rule by the Chair has been noted. Further, the unexpected and unprecedented change of the Order-in-Council - unique in the history of Royal Commissions - saw the federal government actively interfering with the internal workings of a Royal Commission in a manner profoundly consequential for the outcome of its work (the final report). The purpose of Royal Commissions of Inquiry has always been to put the discussion and research of issues of importance to society beyond the political realm. The government's actions - still unexplained and undefended today- effectively frustrated meaningful research and genuine public discussion of the issues raised by science and medicine's new-found ability to create, manipulate and alter human life in the laboratory, by retroactively legitimating the undemocratic actions of the Chair.

The four Commissioners who commenced the legal action were fired 10 days after filing the law suit. Eichler described the implications of their dismissal as follows:[21]

> Having been fired, the four ex-Commissioners lost their standing before the federal Court, and were obliged to drop their suit. The matter of the legality of the second Order-in-Council, and thus the Royal Commission itself, remains unresolved and the Canadian public remains largely unaware of these crucial events surrounding the Commission's activities and use of millions of public funds.

ii. FLAWED PUBLIC PARTICIPATION PROCESS

Christine Massey criticized the effectiveness of the Commission's method in attracting and including the public in a process that should have allowed the public's values and opinions to reflect upon the science and new technologies in question.[22] Public education was restricted to the distribution of information kits to interest groups and to those who requested them. The Commission conducted a national poll to determine the opinions of Canadians towards new reproductive technologies. Massey described the distinctions between the Commission's polling approach and effective public participation as follows:[23]

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[21] *Ibid.* at 203.

[22] C. Massey, "The Public Hearings of the Royal Commission on New Reproductive Technologies: An Evaluation" in G. Bassen, M. Eichler & A. Lippman, eds., *Misconceptions: The Social Construction of Choice and the New Reproductive and Genetic Technologies*, vol. 1 (Hull, Que.: Voyageur, 1993) 237 [hereinafter "Massey"].

> Polling is a passive form of political participation, where the kind of questions deemed important, their context and the range of possible alternatives are determined by the poll designers, according to their goals. This is quite different from engaging in a shared process of decision-making with citizens, where citizens are genuine partners in determining their public policies.

Massey's concern was that a poll which "questions people on complex scientific and ethical issues about which they know little, is no substitute for public participation."[24] Along with her criticism that the method was unsound, Massey also criticized the questions utilized by the Commission. She summarized her assessment of public participation in the research of Commission as follows:[25]

> The Royal Commission on New Reproductive Technologies had the same potential as all commissions to include a wide variety of voices in its deliberations. By not taking action to address the difficulties of public involvement in science policy, the Commission's hearings fell short of their potential. The Commission did not attend to the particular needs of public groups who wanted to be a part of the process or seek innovative and effective methods of participation. The result was to privilege the scientific and legal experts and to miss an opportunity to engage in fruitful public discussion around a complex scientific issue.

Dr. Scorsone's dissenting opinion was consistent with Massey's concerns. Dr. Scorsone stated that the Commission's Decima survey did not ask the Canadian public their views concerning judicial intervention during pregnancy, "confining itself to new reproductive technologies per se."[26] Dr. Scorsone then recommended that the views of Canadians should be "actively and representatively sought before any legislative change is even contemplated."[27]

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[23] *Ibid.* at 245.

[24] *Ibid.*

[25] *Ibid. at* 250.

[26] Report, *supra,* note 1 at 1124.

[27] *Ibid.*

iii. INADEQUATE RESEARCH PROGRAM

Eichler described the most serious problems within the Commission as involving the research program. So serious were the problems concerning the secrecy surrounding the Commission's research program that the Social Science Federation of Canada, (representing 15,000 Canadian social scientists), established a task force to examine the matter. Following several unsuccessful attempts to obtain adequate information from the Commission, the President of the Federation wrote to the Prime Minister urging him to intervene because of the Commission's refusal to provide basic information about the research. The Canadian Association of University Teachers (representing all 60,000 professors in Canada), shared similar concerns as illustrated in a letter written by its President to the Chair, stating that the Association was astonished at the Commission's secrecy concerning the research.[28]

V. THE ETHIC OF CARE

The Commission selected the ethic of care and eight guiding principles as the framework "to identify and express its own normative perspective on the issues it confronted."[29] The Commission's description of its framework was brief and, therefore, is quoted in its entirety:[30]

> Although there are differences of emphasis among the ethical thinkers from whose work we have drawn, the ethic of care holds, broadly speaking, that moral reasoning is not solely, or even primarily, a matter of finding rules to arbitrate between conflicting interests. Rather, moral wisdom and sensitivity

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[28] *Ibid.* at 211.

[29] Patrick Healy, "Statutory Prohibitions and the Regulation of New Reproductive Technologies under Federal Law in Canada," 40 (1995) McGill L. J. 905 at 911 [hereinafter "Healy"].

[30] Report, *supra* note 1 at 52.

> consist, in the first instance, in focusing on how our interests are often interdependent. And moral reasoning involves trying to find creative solutions that can remove or reduce conflict, rather than simply subordinating one person's interests to another. The priority, therefore, is on helping human relationships to flourish by seeking to foster the dignity of the individual and the welfare of the community.
>
> Where intervention is necessary, its aim should be creative empowerment so that, as far as possible, everyone is served and adversarial situations do not arise. At the very least, intervention must, in this view, avoid causing harm to human relationships. The traditional first principle of medicine, non-maleficence (do no harm), is thus applicable not only to medical practice but to intervention in society generally and is made into a positive commitment to empowerment. The concept of non-maleficence goes beyond avoiding actions that might cause harm, to taking steps to prevent harm and create conditions in which harm is less likely to occur and beneficial results are the more likely outcome.

The Commission's emphasis on the need to find creative solutions to reduce conflict and its commitment to empowerment provides a sound basis for directly challenging its application of the ethic of care. For example, the Commission failed to further examine legislative schemes that have the potential to provide creative solutions to prevent substance abuse during pregnancy. Rodger's study on judicial intervention during pregnancy prepared for the Commission referred to legislative schemes utilized by other jurisdictions to address the problem of substance abuse during pregnancy.[31] For example, she referred to the Swedish legislation which provides for mandatory treatment of alcoholics for a period of two months, which can be extended for another two months under certain conditions.[32] She also referred to an incentive program in France whereby pregnant women must observe the requirements of a Public Health Code to receive a prenatal allowance. A portion of the allowance is payable after each prenatal examination.

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[31] S. Rodgers, "Juridical Interference with Gestation and Birth" in Research Studies of the Royal Commission on New Reproductive Technologies, *Legal and Ethical Issues in New Reproductive Technologies Pregnancy and parenthood*, vol. 4 (Ottawa: Minister of Supply and Services Canada, 1993) 1 [hereinafter "Rodgers"].

[32] *Ibid.* at 103.

Pregnant women will be visited by social assistants if their " financial or moral situation requires protection in their homes." [33] Finally, Rodger's study made reference to *The Children's Act* in theYukon which enables the Director of Family and Children's Services to apply to a judge for an order "requiring the woman to participate in such reasonable supervision or counselling as the order specifies in respect of her use of addictive or intoxicating substances"[34] if he has "reasonable and probable grounds to believe and does believe that a foetus is being subjected to a serious risk of suffering from foetal alcohol syndrome or other congenital injury attributable to the pregnant woman subjecting herself during pregnancy to addictive or intoxicating substances." [35] Rodgers noted that the provision was held to be unconstitutional in the *Joe*[36] case. In evaluating the impact of the *Joe* decision, however, Rodgers failed to note that this decision was made primairly on the basis that the term "foetal alcohol syndrome" was not adequately defined.[37] Given the high level of public and governmental concern regarding foetal alcohol syndrome, the recommendations should have at least allowed for further evaluation of legislative intervention.

On the other hand, Dr. Scorsone supported the evaluation of alternative creative approaches to address the problem of substance abuse during pregnancy. For example, she suggested that Canada should address the question:[38]

> of whether severe drug addiction resulting in incoherence or uncontrollable

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[33] *Ibid.* at 99.

[34] *The Children's Act*, S.Y. 1984, C. 2, s. 134 (1).

[35] *Ibid.*

[36] *Joe* v. *Director of Family and Children's Services (Yukon)*, [1987] Y.R. 169.

[37] In a telephone discussion with Ms. Anne Sheffield, Director Family and Children's Services, Yukon, I was advised that the Yukon does not treat the *Joe* decision as binding because the comments concerning its constitutionality were *obiter dicta.*

[38] Report, *supra* note 1 at 1127.

> compulsion is sufficiently parallel to or cognate with severe mental illness in some respects that similar approaches are appropriate.

In this regard, Dr. Scorsone observed that while it is accepted that mentally ill people should not, generally be hospitalized without consent, Canadian society has accepted the proposition that committal is warranted on a "well founded fear that a person will harm himself or herself or someone else..."[39]

The Commission justified its decision not to pursue or evaluate alternative legislative solutions, in part, on the basis of its view that such legislation may cause more harm than good:[40]

> ...there is nothing in our experience to demonstrate that such laws work in practice. Indeed, there is strong evidence to the contrary, particularly because the instruments available to the courts - forcing action under penalty of fines or incarceration - are brutally blunt and patently unsuited to the goal of promoting anyone's health or well-being.

Unfortunately, the Report failed to describe the "strong evidence to the contrary." It noted that the American College of Obstetricians and Gynecologists has taken the position that "resort to the courts is counterproductive and almost never warranted."[41] It also commented that the American Medical Association has reached similar conclusions. However, this is hardly "strong evidence to the contrary." Furthermore, Rodgers study, the sole resource cited in the Report concerning judicial intervention during pregnancy, described medical authorities supporting prenatal intervention in extreme circumstances. In this regard, Rodgers cited the following recommendations of the American Medical Association:[42]

> If an exceptional circumstance could be found in which a medical

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[39] *Ibid.*

[40] *Ibid.* at 964.

[41] *Ibid.* at 959.

[42] Rodgers, *supra* note 31 at 67.

> treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases that do not present such exceptional circumstances.

Clearly, a pregnant woman suffering from severe addiction should have been critically examined as one of the exceptional circumstances referred to by the American Medical Association. This position is consistent with the fact that many jurisdiction have provisions for civil commitment for severe addiction. For example, a study of the use of civil commitment by the States undertaken pursuant to a recommendation of the Bush Administration[43] concluded that "24 states and the District of Columbia have specific, detailed statutory provisions authorizing the involuntary commitment of drug-dependent persons either separate from, or joined with provisions for the commitment of persons with mental illness, alcoholism, or developmental disabilities."[44]

In short, the Report failed to present an objective evaluation of the potential value of creative legislative approaches to address the problem of substance addiction during pregnancy. Rather, the Commission focused on approaches involving fines or incarceration to support its conclusion that such laws may cause more harm than good. Indeed, Dr. Scorsone, even after being involved in all the Commission's deliberations, concluded that there is still a need to evaluate legislative intervention to protect women from the coercion of severe drug addiction:[45]

> Yet we must consider the possibility that in some cases the courts, in mandating treatment, could be acting in defense of a woman's best interests, actual intent

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[43] The White House, *National Drug Control Strategy* 42-43 (September 1989).

[44] S. Anderson Garcia & I. Keilitz, "Involuntary Commitment of Drug Dependent Persons With Special Reference to Pregnant Women" (1991) 15 (4) Mental and Physical Disability Law Reporter 418 at 419.

[45] *Ibid.* at 1125.

> and consent and thus her authentic autonomy, against the coercion she experiences from some other factor in her life, such as severe drug addiction.

Ironically, the Commission's recommendations, if enacted, would render futile further research of creative legislative solutions to prevent substance abuse during pregnancy such as mandatory treatment for prenatal substance abuse.

Other aspects of the recommendations may be directly challenged as being in a conflict with the Commission's ethic of care. It is arguable that the recommendations unreasonably subordinate the interests of the unborn child in preference to the absolute reproductive autonomy of women. It is arguable that mandatory intervention to prevent substance abuse during pregnancy does not produce adversarial relationships but rather prevents those adversarial relationships that may arise from substance abuse during pregnancy. It is well established that substance abusing pregnant women are at risk of loosing custody of their children. They are also involved in a high rate of crime including prostitution and use of illegal drugs. In view of the life long harm incurred to the unborn child as a result of chronic and severe substance abuse during pregnancy, it is arguably not appropriate to apply the concept of non maleficence prior to and apart from an evaluation of the benefit of intervention. Legislative intervention directed at the best interests of mother and unborn child could in fact be a form of creative empowerment.

Substance abuse during pregnancy is a striking example of the interdependency of human beings. Pregnancy is necessary for the continuation of mankind. Women have been biologically equipped to become pregnant and gestate future members of our community. That this future member of our community is totally dependent on his or her mother is reflected by the devastating harm to the unborn child as a direct result of chronic and severe substance abuse during pregnancy. As human beings, we must be cautious how we apply the ethic of care to address the interdependency of mother and unborn child and the biological realities of substance abuse during pregnancy on future members of our community. Unfortunately, the Commission failed to do this.

The Commission primarily relied on the research paper prepared for it by Professor Kymlicka to support its decision to utilize the ethic of care and eight guiding principles.[46] However, as observed by Patrick Healy, the Commission distorted the ordinary usage of the ethic of care suggested by Kymlicka by ascribing to it a broader application, and one that does not coincide with its usage by others in political and ethical debate.[47]

Kymlicka described the ethic of care by contrasting it to the rights/interests model of moral reasoning which abstracts moral principles from a general theory of human nature. The ethic of care however, "emphasizes the importance of attending to responsibilities and the preservation of social relationships, rather than focusing on competing rights."[48] It also "emphasizes the importance of being sensitive to the needs of unique individuals in each case, rather than trying to find universal principles of right conduct that will apply to all cases."[49] Kymlicka observed that proponents of the ethic of care consider it to be more female and necessary to replace or complement the male oriented rights/interests model. This view of the ethic of care is consistent with Healy's observation that the ethic of care was originally developed by the well known feminist

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[46] W. Kymlicka, " Approaches to the Ethical Issues Raised by the Royal Commission's Mandate" in Research Studies of the Royal Commission on New Reproductive Technologies, *New Reproductive Technologies: Ethical Aspects,* vol. 1 (Ottawa: Minister of Supply and Services Canada, 1993) 1 [hereinafter "Kymlicka"].

[47] Healy, *supra* note 29 at 910.

[48] Kymlicka, *supra* note 46 at 10.

[49] *Ibid.*

Carol Gilligan in her book entitled *In a Different Voice.*[50]

Healy described Gilligan's vision of the ethic of care as:[51]

> ... a point of view shared by women in which a sense of personal responsibility and personal autonomy proceeds from an emphatic and altruistic sense of concern and responsibility for others, and not from a selfish absorption in formal constructions of rules or rights.

Gilligan developed this vision by contrasting two different ways of making ethical decisions. She concluded that the predominantly male approach was less mature and directed at a single right answer as if solving a math equation. The typically female, and more mature approach, was to focus on the unique circumstances of each particular dilemma. Ironically, the recommendations to absolutely prohibit judicial intervention during pregnancy are more consistent with the rigid and less mature approach described by Gilligan, than an approach based on the need to individually evaluate each situation. For example, the recommendations preclude the possibility of mandatory treatment for substance abuse during pregnancy even in rare and extreme cases.

The Commission adopted eight guiding principles of particular relevance to its mandate to give concrete expression to the ethic of care: individual autonomy; equality; respect for human life and dignity; protection of the vulnerable; non-commercialization of reproduction; appropriate use of resources; accountability; and balancing individual and collective interests.[52] Kymlicka endorsed the incorporation of guiding principles into the framework because they are less controversial than comprehensive ethical theories and easier to apply than moral theories. However, Kymlicka also emphasized that the guiding principles approach cannot resolve all moral disagreement.[53] This emphasis is consistent with Healy's conclusion that:[54]

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[50] C. Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass: Harvard University Press, 1982). This book is considered by many as having helped to start a revolution in feminism.

[51] Healy, *supra* note 29 at 911.

[52] Report, *supra* note 1 at 52.

> ...the adoption of eight guiding principles in no way resolves the ambivalence of the ethic of care as a justification for the decisions taken by the Commission. Indeed, the *Report* itself provides a striking illustration of this ambiguity in Dr. Scorsone's dissenting views. Dr. Scorsone objects to some conclusions reached by the majority of Commissioners and specifically observes that, in her view, the ethic of care should have led the majority to a different result. Thus, the dissenter and the majority equally claim fidelity to the guiding principles and to the ethic of care.

Kymlicka highlighted the ambiguity of the ethic of care by describing how different interpretations of the ethic of care can lead to diametrically opposed views on the issue of judicial intervention during pregnancy. Some proponents of the ethic of care argue that by focusing on the importance of relationships rather than competing rights, public policy should treat the pregnant woman and her fetus as a single unit and never restrict a woman's rights in the name of her fetus. To the contrary, other proponents of the ethic of care argue that concern for relationships and responsibilities suggests that the law should impose a duty of care on a pregnant woman to protect her fetus.[55]

VI. ANALYSIS OF THE RECOMMENDATIONS

The goal established by the Commission with respect to judicial intervention during pregnancy and birth was to promote "two fundamental values: respect for the rights and autonomy of the pregnant woman and concern for the health and well-being of the fetus."[56] This goal stemmed from the Commission's mandate to reach "conclusions and recommendations that reinforce or re-establish the ethic of care."[57] The analysis that follows establishes that the ethic of care and eight guiding principles do not support the Commission's recommendations to prohibit judicial intervention during pregnancy. To the contrary, the ethic of care mandates further research into creative solutions such as mandatory treatment for prenatal substance abuse.

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[53] Kymlicka, *supra* note 46 at 34.

[54] Healy, *supra* note 29 at 911.

[55] Kymlicka, *supra* note 46 at 10.

[56] Report, *supra* note 1 at 962.

i. OVERVIEW OF THE COMMISSION'S REASONS

The introduction to the Commission's reasons described how technology such as detailed ultra sound images, prenatal diagnosis, and fetal surgery "reinforces the view of the fetus as a separate patient."[58] It implied that this "new way of conceptualizing the fetus"[59] fails to consider the needs of its mother. This perspective raises questions as to whether judicial intervention during pregnancy to prevent substance abuse during pregnancy necessarily gives rise to the risk of creating adversarial relationships between mother and fetus. Is there any potential for judicial intervention to promote the best interests of both?

The Commission's summary of legal reasons to support its recommendations to prohibit judicial intervention during pregnancy was extremely brief. Because "a fetus does not have independent legal or constitutional rights"[60]; and because "women have constitutionally protected rights to equality, liberty, and security of person, as well as the right to refuse medical treatment"[61]; the Commission concluded that:[62]

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[57] *Ibid.*

[58] *Ibid.* at 949.

[59] *Ibid.*

[60] *Ibid.* at 955.

[61] *Ibid.*

> It follows that compelling a pregnant woman to conform to certain standards of behavior, or requiring her to undergo surgery or other invasive procedures, would constitute an unacceptable violation of her individual rights and her equality rights. It would also have adverse effects on the rights of women generally in Canadian society by imposing on pregnant women a standard of behavior not required of any other member of society. As the Supreme Court of Canada has confirmed, discrimination on the basis of pregnancy constitutes sex discrimination.

This conclusion implies that legislative intervention to prevent substance abuse during pregnancy is necessarily unconstitutional. This conclusion however, is highly questionable in light of the *DFG*[63] case where the Supreme Court of Canada repeated almost twenty times that the legislatures must address the issue of substance abuse during pregnancy and implied that substance abuse during pregnancy was an evil that should be corrected by the legislature.[64]

The Commission stated that it relied primarily on ethical reasoning to support its recommendations to prohibit judicial intervention during pregnancy. The foundation of the Commission's view from an ethical perspective was that:[65]

> ...it is ethically (as well as legally) wrong to suggest that pregnant women's rights to make decisions about their medical care and treatment should be changed or lessened because they are pregnant.

The Commission explained that it adopted this position because to treat pregnant women as different from anyone else was detrimental to the perception of women in society:[66]

> ...judicial intervention both emerges from and reinforces a social perception of the role of women in reproduction that instrumentalizes them and devalues their humanity and individuality. At the core of the impulse toward judicial intervention in pregnancy and birth is the view that pregnant women are the

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[62] *Ibid.*

[63] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) [hereinafter *DFG* cited to (1997) S.C.J. No. 96 (QL)].

[64] *Ibid.* at 26.

[65] Report, *supra* note 1 at 957.

[66] *Ibid.* at 959.

> means to an end - the birth of healthy children. To the extent that judicial intervention reinforces the notion that a pregnant woman's role is only to carry and deliver a healthy child, it denies her existence as an autonomous individual with legal and constitutional rights and is dangerous to the rights and autonomy of all women.

While many may hold this opinion and share this concern, serious questions arise concerning the grounds relied on to justify this position, particularly with respect to supportive intervention to assist individuals recover from chronic and severe substance addiction.

Finally, the Commission relied on the perspective that "there is nothing in our experience to demonstrate that such laws work in practice"[67] to justify its conclusion that judicial intervention during pregnancy must be prohibited. The question arises as to how seriously they examined the potential of such laws. For example, it appears that they did not even consider Minnesota's comprehensive legislation directed at the early identification of and voluntary services to drug abusing pregnant women which also provides for the involuntary treatment of the pregnant woman if she refuses voluntary services or fails recommended treatment.[68] Furthermore, how much evidence was necessary to justify mental health laws that authorize the involuntary hospitalization of individuals suffering from severe mental illness who are considered to be a danger to themselves or others?

After rejecting judicial intervention in pregnancy and birth, the Commission addressed the question of "how should society respond to a situation where a woman is not caring for her fetus or engaging in behavior that may harm it?"[69] The Commission concluded that the answer to this question "lies in examining the reasons for that behavior and selecting solutions that address them."[70] This approach led the Commission conclude that both the rights and autonomy of pregnant women and the well being of the fetus are best achieved by providing a "supportive and caring environment in which the [pregnant women] can make informed decisions and choose from among realistic options before and during pregnancy."[71] While there are few who would disagree that this approach is generally preferable, the question still arises as to whether judicial intervention is necessary in rare and extreme cases.

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[67] *Ibid.* at 964.

[68] Minn. Stats Ann. § 626.5561 (West 1996) & Minn. Stats. Ann. § 235b 02 (West 1982 & Supp. 1998). For an excellent discussion of "Minnesota's Answer" please refer to M. Lencewicz, "Don't Crack the Cradle: Minnesota's Effective Solution For the Prevention of Prenatal Substance Abuse-Analysis of Minnesota Statue Section 626.5561" (1994) 63 Rev. Jur. U.P.R. 599.

As the author pondered the Commission's superficial analysis of judicial intervention during pregnancy, it became clear that "rights talk" had impeded "genuine political discourse"[72]. The language used to discuss this critical problem "led to a standoff of one right against another"[73] and ultimately impeded the "ongoing dialogue between freedom and responsibility, individualism and community, present needs and future plans"[74] that is fundamental to law reform directed at the prevention of substance abuse during pregnancy.

ii. THE EIGHT GUIDING PRINCIPLES

The Commission developed "eight guiding principles to act as a prism, casting light on issues where conflicts are likely to arise and guiding them toward ethically based

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[69] Report, *supra* note1 at 961.
[70] *Ibid.*
[71] *Ibid.* at 962.
[72] *Rights Talk, supra* note 7 at xii..
[73] *Ibid.*
[74] *Ibid.* at xiii.

conclusions."[75] This analysis will focus on the principles of autonomy, accountability, equality, protection of the vulnerable, respect for human life, and balancing individual and collective interests. It will establish a firm basis for rejecting the Commission's recommendations arising from its conclusion that "judicial intervention is neither an acceptable nor an effective method of achieving the goal of maximizing the chances for the birth of a healthy child."[76]

a. INDIVIDUAL AUTONOMY

The Commission's description of the principle of individual autonomy focused on the view that individuals must be free to choose how to live, particularly with respect to their bodies. However, it noted that autonomy does not include the right to harm others. Furthermore, restrictions may be necessary if individuals lack the necessary competence to make reasonable decisions:[77]

> By individual autonomy we mean that people are free to choose how to lead their lives, particularly with respect to their bodies and their fundamental commitments, such as health, family, sexuality, and work. Clearly, this is not an unqualified principle. Individual autonomy does not include the freedom to harm others, to use force to coerce them, or to undermine social stability. Moreover, restrictions are sometimes placed on people's freedom of action in circumstances if it is determined that they lack the competence necessary to make reasonable decisions. However, a defining feature of modern culture is that individuals are seen as having the right (and the responsibility) to decide what kind of life they want to lead. From this principle it follows, for example, that actions or decisions that affect people's health, bodily integrity, security and identity require informed consent.

The opinion selected by the Commission to highlight its description of the principle of individual autonomy was that of the Provincial Advisory Council on the Status of

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[75] Report, *supra* note 1 at 56.

[76] *Ibid.* at 964.

[77] *Ibid.* at 53.

Women, Newfoundland. It emphasized that women must have the right to absolute reproductive autonomy:[78]

> Any decision on the regulation of new reproductive technologies must endeavor to balance the interest of all members of society at the same time though the council believes that any policies which are developed must be grounded on the principle that women have the absolute right to decide what happens to our body and to determine our own choices with respect to reproduction and reproductive health care.

The principle of autonomy was particularly influential in the Commission's decision to recommend a prohibition of judicial intervention during pregnancy. The Commission concluded that the "constitutionally protected rights to equality, liberty, and security of person, as well as the right to refuse medical treatment"[79] are fundamental to human dignity and autonomy.

Generally speaking, most would agree that individuals, including pregnant women, must have the right to decide what happens to their bodies. However, Dr. Scorsone's dissenting opinion establishes that the Commission did not adequately consider how severe drug addiction can interfere with one's ability to make independent decisions about their medical care and fulfill their responsibility for deciding "what kind of life they want to live."[80] A critical analysis of the Commission's reasons, particularly in the context of Dr. Scorsone's dissenting opinion, strongly supports the view that the Commission made its recommendations on the ill-founded assumption of "exceptionless, perpetual and unambivalent, unambiguous, consistent and rational choice on the part of women."[81] The Commission failed to consider that judicial intervention such as mandatory treatment for prenatal substance addiction may enhance women's authentic autonomy and actually protect them against the coercion arising from severe drug addiction. In the words of Dr. Scorsone:[82]

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[78] *Ibid.*

[79] *Ibid.* at 955.

[80] *Ibid.* at 53.

[81] *Ibid.* at 1126.

> The recommendation that judicial intervention is pregnancy not be permissible assumes that the court would necessarily be oppressive and coercive in overriding a woman's consent. Yet we must consider the possibility that in some cases the courts, in mandating treatment, could be acting in defense of a woman's best interests, actual intent and consent, and thus her authentic autonomy, against the coercion she experiences from some other factor in her life, such as severe drug addiction.

By definition, the Commission implied that judicial intervention was simply a means to control the behavior of pregnant women when the fetus is thought to be at risk. Dr. Scorsone challenged the Commission's conclusion that judicial intervention during pregnancy is a form of negative control on the grounds that chronic and severe substance abuse may preclude rational and informed choice:[83]

> In some cases as they actually occur in practice there may be doubt as to the competence and hence the nature of the consent of an individual woman. This may be so if she is drug-impaired or in a state of drug withdrawal which would cause her to say or do anything to get a fresh supply, whatever her deeper intent for the fetus might be.

There is a striking contrast between the Commission's view of judicial intervention during pregnancy as being to "control a pregnant woman's behavior"[84] and Dr. Scorsone's focus on the potential of intervention to protect a woman from the coercion she experiences from severe addiction.[85]

Professor Overall, a well known proponent of women's right to reproductive autonomy, is quoted in the Report as supporting the goal of protecting and enhancing "the health of both the fetus and pregnant woman without infringing upon the woman's reproductive autonomy."[86] However, the Report failed to address Professor Overall's qualification of absolute reproductive autonomy:[87]

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[82] *Ibid.* at 1127-28.

[83] *Ibid.* at 1127.

[84] *Ibid.*

[85] *Ibid.* at 1126.

> ...when the fetus is within the woman's body, the maternal/fetal relationship may arguably be regarded as a unity, and the competent woman's informed decisions about the fetus and her pregnancy should prevail.

Professor Overall specifically referred to the "competent woman's informed decisions."[88] This is consistent with the Commission's own description of the principle of autonomy which specifically acknowledged that "restrictions are sometimes placed on people's freedom of action in circumstances if it is determined that they lack the competence necessary to make reasonable decisions."[89] It is ironic, that the Commission's recommendations made no allowance for judicial intervention during pregnancy when the competence of a pregnant woman is seriously jeopardized.

It is arguable that the Report reflected a biased perspective of the public opinion concerning a women's right to reproductive autonomy. The Report stated:.[90]

> As numerous intervenors pointed out in their testimony before the Commission, women do not give up their right to control their own bodies or to determine the course of their medical treatment just because they are pregnant. A woman has the right to make her own choices, whether they are good or bad, because it is the woman whose body and health are affected, the woman who must live with her decision, and the woman who must bear the consequences of that decision for the rest of her life

And what of the numerous arguments from the "pro-life" or "fetal rights" campaigns? The fact that the Commission did not present these arguments or even acknowledge that this is a highly controversial issue in Canada brings to mind the concerns previously discussed that public opinions were not adequately canvassed or represented.

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[86] *Ibid.* at 958.

[87] *Ibid.*

[88] *Ibid.*

[89] *Ibid.* at 19.

[90] *Ibid.* at 954.

The Report's presentation of the *Morgentaler*[91] decision raises questions as to the adequacy of the Commission's research processes. The analysis of the *Morgentaler* decision that follows establishes that the Commission inappropriately utilized that case to support its view that women have a right to absolute reproductive autonomy. Unfortunately, the Commission failed to acknowledge that the Supreme Court of Canada in that case unanimously recognized that the state's interest in the unborn child in some circumstances justifies a restriction of a pregnant woman's reproductive autonomy or freedom of choice. The Report also failed to indicate that Canada's long standing abortion laws contained in the *Criminal Code* were struck down primarily because of procedural inadequacies.

The Report highlighted this summary of the *Morgentaler* decision to suggest that the Supreme Court of Canada supports women's right to absolute reproductive autonomy:[92]

> In its 1988 decision in *R. v. Morgentaler*, the Supreme Court of Canada ruled that, by interfering with their bodily integrity and subjecting them to serious psychological stress, the abortion provisions of the *Criminal Code* (section 251) violated women's rights to liberty and security of the person. The Court found that the abortion provisions impaired women's rights under the *Canadian Charter of Rights and Freedoms* (section 7) and could not be seen as "reasonable limits" that are "demonstrably justified in a free and democratic society" (section 1).
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> In her decision, Justice Wilson characterized section 251 as a violation of pregnant women's constitutional rights on the basis that "In essence, what [the section] does is assert the woman's capacity to reproduce is not to be subject to her own control. It is to be subject to the control of the state. She may not choose whether to exercise her existing capacity or not to exercise it. This is not, in my view, just a

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[91] *Morgentaler* v. *The Queen*, [1988] 1 S.C.R. 30 [hereinafter *Morgentaler*].

[92] *Ibid.*

> matter of interfering with her liberty in the sense...of her right to personal autonomy in decision making, it is a direct interference with her physical 'person' as well. She is truly being treated a means- a means to an end which she does not desire but over which she has no control.

Unfortunately, this quotation misrepresents the overall impact of the Supreme Court of Canada's decision in *Morgentaler*. Justice Wilson's opinion was not that of the majority. She concurred only in result. For example, Justice Wilson was the only justice who "explicitly declared a constitutional right to abortion, and even she acknowledged a legitimate state interest in protecting the life of the fetus/unborn child at some point."[93] The use of Justice Wilson's judgment as if it were the Courts, illustrates the Commission's inadequate presentation of *Morgentaler*. Furthermore, the Commission did not present a reasonable perspective of Justice Wilson's decision. It failed to include Justice Wilson's description of the purpose of the abortion provisions of the *Criminal Code* as being for the protection of the fetus which in her view was a "perfectly valid legislative objective."[94] It also omitted the fact that Justice Wilson addressed the question of when the state's interest in the protection of the fetus justifies intervention. In so doing, she implied that the developmental approach was appropriate. Applying this approach, Justice Wilson declared that a woman's reasons for having an abortion would "be the proper subject of inquiry at the later stages of her pregnancy when the state's compelling interest in the protection of the fetus would justify it in prescribing conditions."[95]

Justices Beetz and Estey's criticism of Justice Wilson's view of the developmental approach indicates that they were prepared to recognize a state interest in the protection of the unborn child throughout the pregnancy. By quoting from a dissenting judgment of Justice Sandra Day O'Connor, the first woman to serve on the American Supreme Court, Justice Beetz and Justice Estey suggested that the state's interest in the protection of the fetus exists from the commencement of life:[96]

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[93] F.L. Morton. *Morgentaler* v. *Borowski Abortion, the Charter, and the Courts.* (Toronto: McClelland and Stewart, 1992) at 232 [hereinafter Morton].

[94] *Morgentaler, supra* note 91 at 181.

[95] *Ibid.* at 182-83.

> The difficulty with this [developmental] analysis is clear: potential life is no less potential in the first weeks of pregnancy than it is at viability or afterward. The choice of viability as the point at which state interest in potential life becomes compelling is no less arbitrary than choosing any point before viability or any point afterward. Accordingly, I believe that the state's interest in protecting the potential human life exists throughout the pregnancy.

The most crucial shortcoming of the Report's presentation of *Morgentaler* is that it did not accurately describe the majority position as to why the abortion laws violated section 7 of the *Charter*. Whereas Justice Wilson was the only Justice who recognized a constitutional right to abortion, "the other four judges who ruled against the abortion provisions did so because they violated the procedural fairness required by section 7, not because there is any independent right to abortion."[97] The fact that the abortion provisions were struck down because of "procedural violations" is inconsistent with the widely held perception that the *Morgentaler* decision supports a women's right to do as she likes during her pregnancy regardless of its impact on the well-being of her fetus. While some may challenge Morton's conclusion concerning "procedural violations," it is consistent with the interpretation of other legal scholars. For example, M. Tushnet presented similar views to Morton on the "procedural violations" issue:[98]

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[96] *Ibid.* at 113. Morton, *supra* note 93 at 246 offered this interesting comment of the *obiter dicta* discussion of the developmental approach:

> Justice Beetz's digression on this point was no less gratuitous than Justice Wilson's. Both were pure *obiter dicta*. They revealed the political calculations that sometimes underlie judicial opinion - writing. By quoting from another Supreme Court justice, Beetz sought publicly to challenge Wilson's claim to privileged knowledge by virtue of her gender. Like Wilson, Beetz anticipated a response by Parliament to the Court's decision. Wilson tried to send one type of message to Parliament, Beetz and Estey responded with a different one.

[97] Morton, *supra* note 93 at 232.

> The court's majority took a different approach. They found the law unconstitutional on what seemed to be procedural grounds. The statute seemed to authorize abortions when permitted by a hospital committee, but, the majority said, the procedures for getting committee approval were so cumbersome that, as a practical matter, abortions-even those the law said would be legal- were extremely hard to obtain.
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> Chief Justice Brian Dickson, for example, found a violation of Section Seven because the abortion law told pregnant women "[at] the most basic, physical and emotional level" that they could not obtain abortions unless they satisfied "criteria entirely unrelated to [their] own priorities and aspirations." The uncertainty about getting approval, and the delays associated with the requirement of the committee increased, made the psychological stress even worse. The delays also increased the risk that women getting abortions would themselves be physically injured by the procedure. Finally, Dickson said, the committees were told to apply a vague standard- whether continuing the pregnancy would endanger the woman's life or health- without any real guidance. Dickson concluded that the abortion law purported to create a defense against a criminal charge, but made the defense "illusory or so difficult to attain as to be practically illusory."
>
> A concurring opinion by two other justices even more clearly relied on procedural problems with the existing statute. Their opinion, like Dickson's, suggested that Parliament might be able to enact a restrictive abortion law without violating the Charter, particularly if it ensured that hospital committees would make decisions quickly.

Rodgers also presented a questionable view of the *Morgentaler* case. Citing Chief Justice Dickson, Rodgers implied that *Morgentaler* stands for the position that the removal of decision-making power of a pregnant woman concerning the decision of whether or not to carry a fetus to term is an unjustified interference with a woman's body and thus a violation of security of person:[99]

> At the most basic, physical and emotional level, every pregnant woman is told by the section that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her

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[98] M. Tushnet, *Constitutional Issues: Abortion* (New York: Facts on File, Inc., 1996) at 97 [hereinafter "Tushnet"].

[99] *Morgentaler*, *supra* note 91 at 466.

> own priorities and aspirations. Not only does the removal of decision making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress... forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspiration, is a profound interference with a woman's body and thus a violation of security of the person.

Surprisingly, there was no mention of the fact that all judges recognized a state interest in the protection of the fetus.

Rodgers described the basic theory underlying the *Charter* according to Justice Wilson in *Morgentaler*. This discussion suggested that the basic theory entails state respect for individual choices to the greatest extent possible. Rodgers stated:[100]

> Madame Justice Wilson, in her reasons for judgment of the *Morgentaler* case, begins her analysis with a consideration of the meaning of the liberty interest protected by section 7. She quotes from MacCormick that liberty is a "condition of human self-respect and of that contentment which resides in the ability to pursue one's own conception of a full and rewarding life." MacCormick continues, "To be able to decide what to do and how to do it, to carry out one's own decisions and accept their consequences, seems to me essential to one's self-respect as a human being." The basic theory underlying the Charter is, according to Wilson, that "the state will respect choices make by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life.

While Justice Wilson's view of the basic theory of the *Charter* is supportable, it does not follow that this theory supports the Commission's recommendations to prohibit judicial intervention during pregnancy. An individual suffering from chronic and severe substance addiction does not "choose" - in any meaningful way - to abuse substances during pregnancy. Rather, the "choice" results from the coercion of addiction.

Rodgers then noted Justice Wilson's example of a violation of the right to security of person:[101]

> State enforced medical or surgical treatment comes readily to mind as an obvious invasion of physical integrity.

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[100] Rodgers, *supra* note 31 at 9.

[101] *Ibid.* at 8.

The implications of this example, in the context of judicial intervention in pregnancy and gestation, are significant. It is a form of state enforced medical or surgical treatment and, therefore, an obvious violation of a person's right to physical integrity. Given the importance of this example, it is surprising that it was essentially "slipped" in and not explained in the context of Justice Wilson's important discussion of reasonable limitations wherein she recognized that the state's interest in the protection of the fetus may justify intervention in limited circumstances.

It is not surprising that Rodgers and the Commission quoted Justice Wilson for her opinion that the abortion provisions of the *Criminal Code* had the effect of treating "women as a means - a means to an end which she does not desire but over which she has no control"[102] in light of their apparent objective of promoting women's right to absolute reproductive autonomy. It is disappointing however, that they failed to present a balanced perspective of this politically potent remark.

Both Rodger's and the Report's discussion of *Morgentaler* highlighted those aspects of the decision which advance a woman's right to reproductive autonomy, yet they failed to adequately consider the reasonable limitations to this right specifically described by Justice Wilson. Rodgers simply stated that the section 7 rights are not absolute.[103] However, there was no indication in Rodger's study or in the Report that the Supreme Court of Canada specifically addressed ways in which this right might be limited. As previously indicated, Justice Wilson, in her examination of the reasonable limits issue, pronounced that the protection of the fetus is a "perfectly valid legislative objective."[104] In the context of abortion, Justice Wilson proclaimed that this interest will "become compelling and justify state intervention in what is otherwise a matter of purely personal and private concern"[105] in the later stages of pregnancy. Clearly these aspects of Justice Wilson's reasons support an inquiry into the state's interest in protecting the fetus of a substance abusing woman who has decided to carry the pregnancy to term.

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[102] *Morgentaler, supra* note 91 at 173.

[103] Report, *supra* note 1 at 9.

[104] *Morgentaler, supra* note 91 at 181.

Many of the issues raised by the Commission in the context of the *Morgentaler* decision must be critically examined in the context of substance abuse during pregnancy. For example, Chief Justice Dickson expressed concern about a women's "own priorities and aspirations"[106] and that "the removal of decision making power"[107] may threaten women in a physical and emotional sense. However, there are strong arguments that women severely addicted to drugs are unable to pursue their own priorities and aspirations. The importance the Chief Justice placed on decision making is an indication for distinguishing chronic and severe substance abuse during pregnancy from other circumstances involving judicial intervention during pregnancy. Because women who are severely addicted to substances have had their decision making power removed or severely jeopardized by addiction, intervention to address the addiction may well enhance rather than threaten a woman's physical and emotional well-being. MacCormick's reference to liberty as being a "condition of human self-respect and of contentment which resides in the ability to pursue one's own conception of a full and rewarding life"[108] raises still further questions in the context of substance addicted pregnant women. When we consider women like Ms. G.,[109] it is difficult to argue that women with a severe addiction problem generally enjoy a condition of human self-respect or that they are able to pursue their "conception of a full and rewarding life." Indeed, it would be extremely difficult for any reasonably informed person to argue that persons suffering from severe addiction are able to carry out their own decisions and accept responsibility for their consequences.

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[105] *Ibid.*

[106] *Ibid.* at 466.

[107] *Ibid.*

[108] N. MacCormick, *Legal Right and Social Democracy: Essays in Legal and Political Philosophy* (Oxford: Oxford University Press, 1982) at 39.

Dr. Scorsone's comments relevant to the Commission's discussion of the *Morgentaler* case were particularly insightful. She disagreed with the Commission's suggestion that pregnant women have no obligation to the fetus because the fetus has not been granted the status of personhood in Canada. She argued that the mother must have some obligation to the fetus as that is the only way that there can be any meaningful content to the state interest in the fetus that was affirmed by the Supreme Court of Canada:[110]

> The Commission report raises the fact that the fetus has not been recognized to have the independent legal or constitutional rights of a person under the law. The woman is seen from this perspective by the report as having no legal obligation to undergo intervention since there is, in effect, no rights-endowed legal person whom she has an obligation not to harm. The report goes on to say that no third party can "volunteer to defend the 'rights' of a being that has no legal existence."
>
> Many questions are raised by this approach.
> Since such a state interest in the fetus does exist, one wonders what meaning it would have were that interest not to be of any force or effect even when a child is about to be born or is viable and the removal of the mother's access to drugs or alcohol or so very routine a medical procedure as a Cesarean section would be sufficient to save his or her life and health. If an interest exists it must have application in some set of circumstances. If that interest were not applicable in these extreme circumstances it would be applicable in no conceivable circumstances which involved a conflict with the woman carrying the child.
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> Since the Morgentaler case focused on abortion, which does indeed involve

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[109] *DFG, supra* note 63.

[110] Report, *supra* note 1 at 1133-34.

> a conflict between the mother and the child *en ventre sa mere*, it is precisely in the welfare of the fetus in the event of some measure of conflict with the mother herself that the Court saw the state to have an interest, rather than in some conflict with another party, such as some individual committing assault on the mother or some corporate entity polluting the available drinking water with teratogenic effects on the fetus.
>
> To argue, then that a woman in principle has the unlimited right to endanger her fetus in any way she wishes at any stage before birth and that no third party, which would include the state, can defend the fetus is to argue that the Court, in finding a state interest in the fetus, had enunciated an absurdity, which I doubt.

Dr. Scorsone's position concerning the *Charter* is consistent with views expressed by Professor Jackman, the *Charter* authority for the Commission.[111] In 1995, Professor Jackman concluded that "the question of whether the foetus is protected under the *Canadian Charter of Rights and Freedoms* has not been directly addressed by the Supreme Court of Canada."[112] However, she acknowledged that the Supreme Court of Canada in *Morgentaler* declared that protection of the fetus could justify certain limitations of a woman's right to reproductive autonomy:[113]

> While the Supreme Court did not directly address the issue whether the foetus is protected under the *Charter* in the *Morgentaler* case, it did suggest that protection of foetal interests might justify certain limits on women's s.7 rights to reproductive autonomy, under s. 1 of the *Charter*. In his judgment for the majority in the *Morgentaler* case, Dickson J. found that protection of the foetus was a sufficiently important legislative objective under s. 1, but that the abortion provisions of the *Criminal Code* did not strike an acceptable balance between the constitutional rights of pregnant woman and the state interest.
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> In her concurring opinion, Wilson J. agreed that protection of the foetus was a valid legislative objective within the meaning of s. 1.

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[111] M. Jackman, "The Constitution and the Regulation of New Reproductive Technologies" in Research Studies of the Royal Commission on New Reproductive Technologies, *Overview of Legal Issues in New Reproductive Technologies*, vol. 3 (Ottawa: Minister of Supply and Services Canada, 1993) 85.

[112] M. Jackman, "The Status of the Foetus Under Canadian Law," (1995) 15 (3) Health Law in Canada 83 at 84 [hereinafter Jackman].

[113] *Ibid.*

If we accept Dr. Scorsone's position that the Supreme Court of Canada did not "enunciate an absurdity," it reasonably follows that we must also accept that the Supreme Court of Canada acknowledged that a woman's right to reproductive autonomy is not absolute. Indeed, the Supreme Court of Canada declared that a woman's right to abortion services may be limited because of the state interest in the fetus. Surely, this is an indication that a woman's "right" to abuse substances during a pregnancy that she has decided to carry to term may also be limited because of the state's interest in the fetus. Particularly if the intervention is directed at the best interests of both the mother and her unborn child.

The view that *Morgentaler* established women's right to reproductive autonomy continues to be widely promoted by highly influential interest groups. In fact, the Commission and Rodgers presented a similar view of the *Morgentaler* decision. However, it is simply not a fair or accurate representation of what was actually decided by the Supreme Court of Canada. Contrary to popular belief, the Supreme Court of Canada's decision in *Morgentaler* did not establish women's right to abortion services or absolute reproductive autonomy. Nor did it denounce any state interest in the unborn child.

In summary, the Supreme Court of Canada decision in *Morgentaler* clearly recognized that a woman's right to reproductive autonomy is not absolute. However, the Report's discussion of *Morgentaler*, while advancing a woman's right to unqualified reproductive autonomy, failed to develop a balanced perspective of that decision. The Commission attributed such significance to a woman's right to reproductive autonomy that this principle was indeed treated as if to be sacrosanct, even in light of compelling authorities indicating that it is not. The Commission relied on politically potent arguments to advance its perspective. However, in its zeal to promote women's right to reproductive autonomy, the Commission failed to present a balanced examination of the relevant issues. The Commission also failed to justify its conclusion that the principle of individual autonomy mandates a prohibition of judicial intervention to prevent substance abuse during pregnancy.

b. EQUALITY AND ACCOUNTABILITY

The principle of accountability was not considered by the Commission in context of judicial intervention during pregnancy. However, the balancing effect of the principle of accountability on the principle of equality was the central theme to Dr. Scorsone's disagreement with the Commission's conclusion that the principle of equality establishes that treating pregnant women different from anyone else is never justified.

The Commission's view of women's constitutionally protected rights versus the absence of legal status of the fetus was relied on to support its conclusion that judicial intervention during pregnancy violates a woman's right to equality and is "not justified on any grounds."[114] The Commission also relied on the legal argument that "the Supreme Court of Canada has confirmed, discrimination on the basis of pregnancy constitutes sex discrimination."[115] To the contrary, Dr. Scorsone concluded that to hold women accountable for the gestation of her fetus that she has decided to carry to term is to hold women to the same standard of responsibility for one's actions as is applied to the rest of society.[116] In view of the overlap of these principles they are addressed together.

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[114] Report, *supra* note 1 at 955.

[115] *Ibid.*

The principle of accountability was described by the Commission as follows:[117]

> The principle of accountability means that those who hold power, whether in government, medicine, technology or other fields, are responsible for the way they use that power. This entails the conviction that Canadian society has a right -and a responsibility- to regulate and monitor how reproductive technologies are used to ensure that our values, principles, and priorities are being respected....

The Commission's description of the principle of accountability focused on the public responsibility to regulate new reproductive technologies rather than individual accountability for one's actions. Dr. Scorsone, however, focused on individual responsibility for one's choices:[118]

> The Commission report says that pregnant women "are no different from any other responsible individual; to treat pregnant women differently from other women and men, or to impose a different standard of behavior on them is neither morally nor legally defensible." It should be clear by this point that I agree. Where we disagree is on the application. Autonomy is a necessary good, but it is not an absolute. All of us have, as the report says, the right to make our own choices, but rights necessarily entail responsibilities; where our choices may or do harm others, our choices are, in fact, limited, and we are held accountable, whatever our gender. It is the suspension of that accountability with respect to pregnant women which would constitute the setting of a different (and lower) standard of behavior.

The author is not aware of any good reason why the Commission failed to address the principle of accountability. It may be that they decided that it was not necessary to do so in view of their conclusion that treating pregnant women different from anyone else is never justified. And yet the Commission itself asserted that "the interests of the fetus are worthy of protection."[119] In fact, the Commission recognized that:[120]

> what transpires before birth - the behavior of the woman during pregnancy, the

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[116] *Ibid.* at 1132.

[117] *Ibid.* at 57.

[118] *Ibid.* at 1130-1131.

[119] *Ibid.* at 957.

[120] *Ibid.*

> provision of medical treatment to her and to the fetus - can seriously affect the health and well-being of the child that is eventually born. Society therefore has an interest in promoting the prenatal health and well-being of the fetus and of the woman carrying it.

What then, could be the response of the Commission to the inconsistency where, on the one hand, it states judicial intervention is never justified and, on the other hand, it asserts that the interests of the fetus are worthy of protection? The implied response is that "the most effective way of caring for the fetus is through appropriate support and caring for the pregnant woman."[121] The author firmly supports the Commission's recommendations concerning the need for "appropriate support services for pregnant women and young women in potentially vulnerable groups."[122] However, the work of the Commission does not support the conclusion that this is necessarily always "the most effective way of caring for the fetus" in circumstances involving chronic and severe substance abuse.[123]

The Commission's description of the principle of equality focused on the needs of underprivileged groups. It was defined in the Report as follows:[124]

> The principle of equality means that every member of the community is entitled to equal concern and respect. The view that the well-being of each person matters and matters equally precludes any social practice that reflects or perpetuates the assumption that some people's lives are worth less than others. Adopting the principle of equality keeps this tenet in view.
>
> The principle of equality forms the basis for our particular concern with ensuring that the interests and concerns of Canadians in all their diversity are taken into account in decisions about new reproductive technologies. This is why we have examined specifically how the technologies affect women, members of racial and ethnic minorities, people with disabilities, Aboriginal people, and lesbians. We recognize that achieving equality sometimes requires special steps to ensure that groups that have experienced discrimination in the past are placed on an equal footing with other members of society....

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[121] *Ibid.* at 964.

[122] *Ibid.* at 965.

[123] *Ibid.* at 1134.

[124] *Ibid.* at 54.

Dr. Scorsone developed a bold argument in support of her position that to hold women responsible for the gestation of the fetus is not a violation of the principle of equality but rather adherence to the principle of equality as well as to the principle of accountability, i.e. accountable to the same standard of behavior as other members of the community. Dr. Scorsone's line of reasoning will be considered in some detail as it is a particularly revealing approach to issues related to legal intervention to prevent substance addiction during pregnancy.

Dr. Scorsone initially addressed "the question of a woman's accountability for her actions"[125] in pragmatic terms. At the outset of this discussion she distinguished cases involving abortion from other cases involving judicial intervention during pregnancy:[126]

> We must deal with question of accountability for her actions. The case of judicial intervention pregnancy is different from that of abortion, in that the child is to be born and, if surviving, he or she will have to live with whatever the consequences of the conflict turn out to be. Fetal alcohol syndrome, brain damage from oxygen deprivation at the time of birth, and the results of being born with cocaine or heroin addiction are among the more common of such consequences.

Dr. Scorsone then examined the issue of accountability from a principled perspective, which in her view, boiled down to a "question of proportion."[127] The implication of this discussion was that, in narrowly defined circumstances, the balance of proportion favors intervention. In this regard she stated:[128]

> There can be no doubt that the inconvenience or loss of mobility or other effects experienced by a woman of mandatory but temporary care or treatment would be far less severe than the effects of an entire lifetime of mental and/or physical handicap on the child who is to be born.

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[125] *Ibid.* at 1129.

[126] *Ibid.* at 1129-1130.

[127] *Ibid.* at 1130.

[128] *Ibid.*

This example challenges the Commission's conclusion that forcing a pregnant woman to accept medical intervention is never justifiable.

Dr. Scorsone dismissed as "alarmist" the Commission's concern that holding a pregnant woman accountable could lead to a "staggering" curtailment of women's choices.[129] She observed that a "significant segment of the literature paints just such bizarre scenarios representing judicial intervention in pregnancy as the harbinger of some total and coercive (male) medico-governmental dictatorship over women."[130] However, Dr. Scorsone wisely viewed "the painting of such extremes, however, or rather the setting up of such straw men"[131] as obscuring the more realistic scenarios which she described concerning the question of proportion and mandatory treatment for substance addiction. The important question identified by Dr. Scorsone was "whether women are not responsible in principle, and therefore what the implications of the question itself are for the status of women before the law."[132]

Dr. Scorsone answered this question by illustrating that it is "the suspension of that accountability with respect to pregnant women - which would constitute the setting of a different (and lower) standard of behavior."[133] Why should pregnant women not be responsible, just as an employer is responsible to provide a safe work environment, and a property owner is responsible for hazardously maintained property? Dr. Scorsone concluded:[134]

> It seems to me that the rationale would have to be that a woman is either

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[129] *Ibid.*

[130] *Ibid.*

[131] *Ibid.*

[132] *Ibid.*

[133] *Ibid.* at 1131.

[134] *Ibid.*

above or beneath the law on grounds of gender and pregnancy, assertions which one may question.

Dr. Scorsone's conclusion that women should be responsible for their pregnancy is related to her assertion that women make a choice in becoming pregnant:[135]

> A woman, unless she has been raped, has in some measure willed her pregnancy at least to the degree that she consensually participated in the sexual union which initiated it. If family planning was not used, she participated in that choice also. Is she not to be deemed responsible for the environment she provides the one who is there at her initiative, even as the employer is responsible for the environment he or she provides for the employee who is there at his or her initiative? A householder who is liable for injury suffered by a person on his or her hazardously maintained property provides yet another parallel.

Dr. Scorsone concluded by further explaining why accountability for the gestation of one's fetus that will be carried to term is not discrimination:[136]

> Be it granted, only a woman can become pregnant, as only a man can produce sperm. Neither fact is discriminatory; they are simply an empirically observable given, a function of the highly adaptive, population-variability-maintaining sexual dimorphism that human beings share with most organisms above the evolutionary level of the worm. Granted, too, given the unique human capacity for awareness and, with that, the development of the philosophy and ethics of social and legal responsibility, that there may therefore be modes of exercise of responsibility which are possible only for a woman, as there are other modes of of responsibility which are possible only for a man.
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> The standard of behavior, however, is the same. While one ought to act in accord with the principles of benevolence and care, that is in ways which are supportive of and helpful to others, at a minimum one is free to act as one wills so long as one acts in ways which do not harm others. As only a woman can, by her own drug abuse or others actions, severely handicap someone for life, only a man can rape. That only one gender can do one or the other form of harm does not make accountability for either discriminatory. The single standard of behavior pertains to both.

Dr. Scorsone's observation that only a pregnant woman, by her own drug abuse, can severely handicap someone for life brings into question the validity of the Commission's argument that just as parents are not forced to undergo medical treatment on behalf of their living children, pregnant women certainly should not be forced to undergo medical treatment on behalf of their unborn children. In support of its view that judicial intervention is never justified, the Commission argued:[137]

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[135] *Ibid.*

[136] *Ibid.* at 1131-1132.

> By forcing medical intervention, society would be requiring pregnant women to do something that is asked of no other individual: to undergo medical treatment for the benefit of another. Even a living child has no right to force a parent to undergo medical procedures for the child's benefit, however morally compelling the case might be. The infringement of bodily autonomy and bodily integrity is not justified on any grounds.

The problem with Commission's argument is that parents and pregnant women are not similarly situated in terms of the implications of substance abuse during pregnancy. Parent's drug abuse does not expose their children to a high risk of life long handicaps whereas a pregnant woman's drug abuse does expose her unborn child to that risk. However, if a parent's behavior does threaten the well-being of their child such that the child is deemed to be in need of protection according to provincial child welfare legislation, it is well established that the state must intervene in the best interests of the child.

The author is not contending that Dr. Scorsone's argument concerning accountability, however brilliant, is airtight or that it represents the position that ought to be adopted as the Canadian position. However, Dr. Scorsone's valuable perspective concerning accountability must be addressed by Canadians prior to any decision to implement the Commission's recommendations concerning judicial intervention during pregnancy.

Whereas Rodgers and the Commission ignored the principle of accountability, they considered the principle of equality in detail. The author's reasons for disagreeing with their applicationof this principle to the issue of judicial intervention during pregnancy will now be presented.

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[137] *Ibid.* at 961.

Rodgers briefly examined the scope of equality rights and pregnancy as sex-based discrimination in the context of the *Charter*. She utilized decisions of the Supreme Court of Canada to support her conclusion:[138]

> In measuring juridical interference with reproductive autonomy for Charter compliance, we may find instances where section 15 protection has been violated.

Rodgers described Section 15 of the *Charter* as prohibiting discrimination on the grounds of sex, race, color, and age. She relied on *Brooks v. Canada Safeway Ltd.*[139] to advance her argument that:[140]

> the Supreme Court of Canada held clearly and decisively that discrimination on the basis of pregnancy or reproductive capacity constitutes sex discrimination in violation of section 15.

Rodgers then cited Chief Justice Dickson to support her conclusion:[141]

> Discrimination on the basis of pregnancy is a form of sex discrimination because of the biological fact that only women have the capacity to become pregnant.

Unfortunately, Rodgers failed to address the view presented by Dr. Scorsone that holding a pregnant women accountable for the implications of her substance abuse is simply holding her to the same standard of behavior of other members of society, i.e." just as a employer is responsible for the environment he or she provides for the employee who is there at his or her initiative."[142]

The Commission adopted Rodger's view of the *Brooks* decision to support its conclusion that judicial intervention during pregnancy violates women's constitutionally guaranteed right to equality. In so doing however, it inaccurately presented the *Brooks* decision in the Report. It over-generalized, and applied out of context, the Supreme Court of Canada's finding in *Brooks* that "discrimination on the basis of pregnancy is discrimination on the basis of sex."[143]

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[138] Rodgers, *supra* note 31 at 9.

[139] [1989] 1 S.C.R. 1219 [hereinafter *Brooks*].

[140] Rodgers, *supra* note 31 at 10.

[141] *Brooks, supra* note 139 at 1242.

[142] Report, *supra* note 1 at 1131.

The *Brooks* decision concerned a benefit plan where by pregnant women received significantly less favorable treatment than did other employees of Safeway. They were not entitled to any compensation for a 17 week period calculated in relation to the time of child birth. The Supreme Court of Canada rejected Safeway's argument that "pregnancy is a voluntary state and should not be compensated since other types of voluntary leave are not compensated."[144] The Court concluded that an employer acts in a discriminatory manner if it excludes pregnancy as a valid claim under a plan of compensation. However, there is a tremendous leap in logic if this reasoning is to be extended to support an unqualified prohibition against judicial intervention during pregnancy. For example, the *Brooks* decision dealt with an arbitrary decision to exclude pregnant women from a plan of compensation. Safeway's argument clearly undermined society's responsibility for some of the financial implications of child birth. On the other hand, there are many circumstances when judicial intervention during pregnancy cannot be considered arbitrary. For example, as Dr. Scorsone has pointed out, the only way the state can enforce its Supreme Court of Canada affirmed compelling interest in the protection of the unborn child from prenatal substance abuse is through the mother.

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[143] *Brooks, supra* note 139 at 1242.

[144] Ellen E. Hodgson, "Pregnancy as a Disability" (1993) 1 Health Law Journal 119 at 124.

Similarly, Professor Jackman's[145] view of the *Brooks* decision does not support the implications of that decision suggested in the Report. Professor Jackman's position, even after the Supreme Court of Canada decision in *Brooks*, was that the meaning of section 15 equality rights had not been directly assessed by the Supreme Court of Canada.[146] Professor Jackman interpreted the *Brooks* decision as establishing that distinctions based upon pregnancy, including legislative protection for the unborn children, is still an option provided that it can be justified under s.1 of the *Charter* as demonstrably justified in a free and democratic society. On the issue of mandatory treatment for substance abuse, Professor Jackman suggested that a determination of whether mandatory treatment for substance abuse during pregnancy is demonstrably justifiable will involve an evaluation of the availability of treatment programs and prenatal care:[147]

> As described above, unwanted medical treatment of pregnant women constitutes a clear violation of their right to life, liberty and security of the person under s. 7 of the Charter, and to equality under s.15. To be upheld, judicial orders or statutory provisions threatening or compelling pregnant women to undergo unwanted medical treatment of control must survive review under s. 1 of the Charter.
>
> So, for example, forcing pregnant women to undergo unwanted medical treatment or surgical intervention on the basis of their general attitude towards their pregnancy, their prior child-rearing history, their prior relationship with social welfare authorities, their behavior as a consequence of socio-economic circumstances, the actions of their spouses, and the unavailability or prenatal health care services meeting their specific needs, will be unconstitutional. Even in more extreme circumstances, such as those involving potential drug dependency of the foetus, or alcohol related damage to undergo unwanted medical treatment must be carefully assessed. It must be born in mind that drug or alcohol dependency does not, *per se*, reduce the scope of a pregnant woman's constitutional rights, whether

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[145] *Jackman, supra* note 111. As previously indicated, Jackman was the constitutional authority for the Commission.

[146] *Jackman, supra* note 112 at 84.

[147] M. Jackman, "The Canadian Charter as a Barrier to Unwanted Medical Treatment of Pregnant Women in the Interests of the Foetus" (1993) 14 (1) Health Law in Canada 49 at 56.

> to security of the person or to equality, and that factors such as access to drug or alcohol treatment programs during pregnancy and the availability of suitable prenatal care will weigh into the s. 1 calculus whether unwanted medical treatment represents the least intrusive way of protecting foetal interests.

Clearly Professor Jackman acknowledged the potential for legislative intervention to prevent substance abuse during pregnancy. Again, the discrepancy concerning the *Brooks* decision between the Commission and its own resource person on constitutional issues brings to mind the concerns previously identified regarding the Commission's research programs.[148]

Professor Jackman also expressed that other statutory restrictions applicable only to pregnant women may also be justified under s. 1 of the *Charter*:[149]

> The courts have indicated that specifically worded legislation, showing a clear intention to include the foetus, would be required to confer legal status or rights on the foetus under civil, common or criminal law. It would, therefore, be open to Parliament or to the legislatures to modify the current state of the law by including the foetus in specific terms under tort, family, property, criminal or other legislation within their respective legislative jurisdictions. As pointed out above, where such legislation interfered with other constitutional rights, such as maternal right under ss. 7 or 15 of the *Charter*, it would have to be justified under s. 1.

The final issue to address concerning the principle of equality is the Commission's suggestion that judicial intervention during pregnancy is also discrimination on the basis of race, socio-economic status, and culture. For example, the Report stated:[150]

> Few cases have reached the courts in Canada, because most women likely to encounter this situation are often in no position to resist and therefore they comply with the wishes of a physician or child welfare authority. An examination of the cases that have been reported shows that the women most likely to be subjected to judicial intervention are disproportionately poor, Aboriginal, or members of a racial or ethnic minority- all factors that influence their capacity to resist intervention. Whether overt discrimination is at work or whether the life circumstances of these women are such that their behavior during pregnancy is more likely to come under scrutiny is difficult to disentangle.

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[148] Eichler, *supra* note 8. See also Massey, *supra* note 9.

[149] Jackman, *supra* note 112 at 85.

[150] Report, *supra* note 1 at 153.

The Report's suggestion that judicial intervention during pregnancy may involve racial and socio-economic discrimination is consistent with Rodgers conclusion that:[151]

> In both Canada and the United States, the women who are the subject of interference with gestation and birth are those who are subject to state scrutiny because of their economic vulnerability and previous engagement with the state in order to obtain needed services. In the United States, clear evidence is available that racism operates in the selection of women who are made the subject of surveillance and scrutiny. There is also clear evidence of cultural insensitivity by members of the dominant culture to the health care needs of other communities.

Dr. Scorsone, however, challenged this politically effective argument on the basis that it was not supported by adequate research:[152]

> It has been alleged by some (and is implied as a distinct possibility in the text of the Commission report) that the high proportion of cases of judicial intervention in pregnancy which involves the poor and members of visible minorities is due to racism and class discrimination in the medical and judicial systems. This is easy enough to assert, and carries a potent political impact. We as a Commission have not, however, been given a fully documented social analysis of such cases including adequate evidence corroborating bias. We have not seen, for instance, a retrospective random or universal sample study of judicial decisions rendered to middle-class/working-class as compared with poor women, or white and visible minority women.

Dr. Scorsone's acknowledgment that the Commission was not provided with a social analysis indicating that judicial intervention during pregnancy reflects overt discrimination again, raises concerns about the Commission's research programs. The possiblity that the Commission may not have adequately examined the views of minority populations is reflected by the fact that intervenors representing aboriginal communities in the appeal to the Supreme Court of Canada in *DFG* submitted evidence "to urge upon this Court the creation of a legal remedy to use in their fight against FAS/FAE."[153] These intervenors further submitted that "such a remedy would be consistent with the aboriginal world view and that the common law should be expanded to help what is particularly an aboriginal problem."[154]

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[151] Rodgers, *supra* note 31 at 89.

[152] Report, *supra* note 1 at 1136.

[153] *DFG, supra* note 63 at para. 88.

Rather than prohibiting judicial intervention during pregnancy because of possible discrimination, Canadian society must address the underlying cause of substance abuse during pregnancy such as the intergenerational nature of addiction relating to dysfunctional parenting skills and family breakdown as a result of addiction. This position is consistent with Professor Glendon's most recent book entitled *Seedbeds of Virtue*[155] which is an effort "to initiate the development of more comprehensive, coherent, and useful ways of thinking, speaking and acting on family issues."[156] When addressing the problem of substance abuse during pregnancy, we must acknowledge the circumstances of child-raising households now amounts to a national crisis. We must address the fact that unless an appropriate response to substance abuse during pregnancy is developed, "many of the nation's children will never have a chance to develop their full potential as human beings, that the quality of the nation's work force will suffer (with adverse consequences for our social security system and our competitive position in the world economy), and that crime and delinquency will spiral ever more wildly out of control."[157]

c. BALANCING INDIVIDUAL AND COLLECTIVE INTERESTS

The Commission described the principle of balancing individual and collective interests as follows:[158]

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[154] *Ibid.*

[155] M.A. Glendon & D. Blankehorn eds., *Seedbeds of Virtue* (New York: Madison Books, 1995) [hereinafter *Seedbeds*].

[156] *Ibid.* at 1.

[157] *Ibid.*

> This principle reflects our belief that both individual and collective interests are worthy of protection, and that individual interests do not automatically take precedence over collective interests, or vice versa. The individual interests with which we are concerned include those of women or couples seeking assisted conception or prenatal diagnosis services, those of gamete donors, and those of children born as a result of a new reproductive technology. The collective interests include those of society as a whole, as well as those of identifiable groups within society, such as women, children, people with disabilities, and members of racial or ethnic minorities.

The principle of balancing individual and collective interests is related to the Commission's conclusions concerning the principles of autonomy and equality. The Commission concluded that judicial intervention during pregnancy has "adverse effects on the rights of women generally in Canadian society by imposing on pregnant women a standard of behavior not required of any other member of society."[159] The adverse effects are described by the Commission as having "serious implications for the autonomy of individual women and for the status of women collectively in our society."[160] Unfortunately, neither Rodger's study nor the Report justified this conclusion. Rather, this conclusion appeared to be simply the opinion of the Commission. Rodger's study referred to Justice Wilson's view in *Morgentaler* that the abortion provisions of the *Criminal Code* have the effect of treating a pregnant woman "as a means - a means to an end which she does not desire but over which she has no control."[161] However, this statement does not justify the Commission's conclusion that judicial intervention "reinforces the notion that a pregnant women's role is only to carry and deliver a healthy child."[162]

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[158] Report, *supra*, note 1 at 57.

[159] *Ibid.* at 955.

[160] *Ibid.*

[161] *Ibid.* at 1128.

[162] *Ibid.* at 959.

Dr. Scorsone disagreed with the Commission's application of the principle of balancing individual and collective interests:[163]

> Arguments opposing judicial review in individual cases on grounds of a posited effect on the collective status of women or on the autonomy of all individual women seem to me to have serious internal contradictions, and to leave insufficient room for sensitivity to these specific individual woman's interests and situations.

Dr. Scorsone argued that to focus on the implications of judicial intervention during pregnancy on the collective status of women has the effect of using individual women to promote a political agenda that may be quite unrelated to their own needs and desires:[164]

> The individuals, women and children, who are caught in these tragic situations are not being treated in these arguments as ends in themselves but more a secondary means to a separate and arguably unrelated political end, an end concerning which the individual women in these conflicts may have no - or some other - personal awareness or commitment. It is they, the individual women, however, who will be left with the care of the handicapped child, or with the bereavement, which follows non-intervention.

Dr. Scorsone stated that judicial intervention in rare instances of grave circumstances does not in any way reinforce the position that a woman's *only* role is to carry and deliver a healthy child. She observed:[165]

> Indeed I know of no group anywhere on any contemporary political or philosophical spectrum which claims that the delivering of a healthy child is a woman's- or a pregnant woman's - only role. When the subject is raised, the notion is universally condemned. It is hence a red herring, however politically potent the slogan.

Dr. Scorsone went further than to simply argue that the Commission's conclusions concerning the implications of judicial intervention during pregnancy on the collective status of women were not justified. She argued that the position that women are not responsible in some way for the gestation of a healthy child has serious implications on the collective status of women:[166]

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[163] *Ibid.* at 1128.

[164] *Ibid.*

[165] *Ibid.*

> If, as must be the case, women are to be deemed equal, women must be deemed to have the full responsibilities which accompany full rights. We expect every adult to act responsibly with respect to the roles they freely undertake, and with respect to the persons to whom they have undertaken both the rights and the obligations which characterize those roles. To expect that pregnant women act responsibly as we expect every other adult to act is to uphold and defend the rights of women as competent, free and full participants in society. It is the negation or the waiving of those responsibilities which, in my view, would be 'dangerous to the rights and autonomy of all women.'

The Commission's reasons in support of its recommendations to prohibit judicial intervention during pregnancy reflect a fundamental concern for the collective status and rights of women, particularly pregnant women. It is clear that this concern has arisen because of the numerous ways women have been oppressed throughout history. Obviously, Canadians must continue to address the injustices that woman have experienced and continue to experience. However, the author strongly disagrees with the Commission that the way to address these concerns is by absolutely prohibiting judicial intervention during pregnancy. In fact, the author agrees with Dr. Scorsone that the effect of such drastic measures will be "ultimately counterproductive to furthering the equality of men and women within our common humanity."[167]

d. RESPECT FOR HUMAN LIFE AND PROTECTION OF THE VULNERABLE

The principles of respect for human life and protection of the vulnerable overlap in a manner that requires a joint examination of their influence on the issue of judicial intervention during pregnancy. The Commission described the principle of respect for human life and dignity as follows:[168]

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[166] *Ibid.* at 1129.

[167] *Ibid.*

> All forms of human life (and indeed human tissue in general) should be treated with sensitivity and respect, not callousness or indifference. Although the law does not treat zygotes, embryos, and fetuses as persons, they are connected to the community by virtue of their origins (having been generated by members of the community) and their possible future (their potential to become members of the community). Not only all persons but also zygotes, embryos, and fetuses should be treated with appropriate respect because of this.

The Commission described the principle of protection for the vulnerable as follows:[169]

> Vulnerability relates to power imbalances, and this principle requires that the welfare of those who are less capable of looking after themselves or who are open to exploitation for various reasons be given special consideration. The most common example concerns the welfare of children. Since children cannot look after all their own needs, parents have the authority to make decisions for them. However, this authority is a trust to be exercised for the benefit of the children, and the state is responsible for ensuring that this trust is kept. Vulnerability to exploitation may also arise from a person's socioeconomic status, membership in a minority group, or disability. Safeguards exist to ensure that adults who are temporarily or permanently unable to make competent decisions are not ignored or taken advantage of; someone is appointed to make decisions on their behalf and must act in their best interests. Society also has a responsibility to ensure that vulnerability is reduced where possible and those who are vulnerable are not manipulated or controlled by those in positions of power and authority.

Although the Commission did not apply the principle of respect for human life to its discussion of legal issues, it commented from an ethical perspective as follows:[170]

> Regardless of whether a fetus is a "person" with "rights," it is clear that the interests of the fetus are worthy of protection: what transpires before birth - the behavior of the woman during pregnancy, the provision of medical treatment to her and to the fetus - can seriously affect the health and well-being of the child that is eventually born. Society therefore has an interest in promoting the prenatal health and well-being of the fetus and of the woman carrying it.

The question identified by the Commission was therefore how does or should society promote maternal and fetal well-being? Unfortunately, the Report did not adequately address this critical question in concluding that judicial intervention during pregnancy should be prohibited.

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[168] *Ibid.* at 55.

[169] *Ibid.*

[170] *Ibid.* at 957.

The Commission concluded that measures related to judicial intervention during pregnancy are "not effective in achieving its goal of protecting fetal well being."[171] In support of this conclusion, the Commission reasoned:[172]

> If women knew that they could be confined against their will, forced to submit to medical treatment or charged with criminal offenses, they might well avoid seeking medical care.

Fortunately, the Commission, itself, stated that women "might" avoid medical care if they knew that they may be confined against their will. Indeed, the research of the Commission did not present research indicating that this, in fact, would happen or that this risk outweighs the benefits of intervention. Furthermore, as discussed in chapter two, in 1995 the Addiction Research Foundation concluded "policy - oriented arguments about the effectiveness or harm of mandated and coerced treatment do not rest on a solid empirical foundation."[173] This same research further concluded that mandated treatment may potentially provide a cost effective solution to the social problems resulting from alcohol and substance abuse.[174] Finally, concern that mandatory treatment may cause people in need of medical care to avoid the health care system did not prevent the use of mental health legislation to commit to hospital people suffering from severe mental illness who may be a danger to themselves or others. Nor did it prevent the use of child welfare or domestic violence legislation.

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[171] *Ibid.* at 960.

[172] *Ibid.* at 957.

[173] Mandated Treatment and Coercion Working Group, by C. Wild et. al., Social Evaluation and Research Department, Addiction Research Foundation, *Mandated and Coerced Treatment for Substance Abuse: Current Knowledge and Future Research Directions* (Toronto: Addiction Research Foundation of Ontario, 1995).

[174] *Ibid.*

Rodger's study offered some support for the position that judicial intervention during pregnancy may not achieve the goal of promoting maternal and fetal well being. Reference was made to a report of the Royal College of Physicians and Surgeons of Canada concerning the physicians responsibility to the mother and the fetus.[175] This report supported "care-orientented counselling" as opposed to judicial intervention during pregnancy. The Report expressed concern for the "harm done to the mother infant bond" where there is a forceful violation of the mother's body in the interests of the fetus.[176] Rodger's study also referred to a statement released by the California Public health Association after the highly publicized and criticized prosecution of a pregnant woman for her drug related behavior during pregnancy.[177] The statement expressed the opinion that "prosecution is counter productive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination."[178] Unfortunately, no effort was made to distinguish cases involving prosecution from other methods of judicial intervention during pregnancy referred to in the study such as supportive intervention directed at assisting individuals recover from severe addiction.

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[175] The Royal College of Physicians and Surgeons of Canada, Biomedical Ethics Committee, "Reflection on the Physician's Responsibility to Mother and Fetus" Submission to the Royal Commission on New Reproductive Technologies, Ottawa, 1990.

[176] *Ibid.*

[177] California Medical Association, as quoted in *Johnson* v. *State* (1991), 578 So. 2d 419 at 426.

[178] *Ibid.*

Rodger's raised the critical question of whether coercive measures of what ever kind are ever an appropriate response to drug and alcohol issues.[179] Her response to this critical question was that the "recent literature on addictions clearly concludes that coercive measures are seriously inadequate and are counterproductive." [180] However, she offered little evidence in support of this conclusion. The author, therefore, does not accept the reasoning that although the state has an interest in the protection of the fetus, judicial intervention is intolerable because it is counter productive to fetal well-being. The evidence simply does not establish that judicial intervention is counter-productive. Clearly, significant further research of the potential value of legislative intervention during pregnancy, including mandatory treatment for chronic and severe substance abuse during pregnancy, is indicated prior to any final decisions are made based on suggestions that judicial intervention may be ineffective. Particularly in view of the fact that South Dakota passed legislation effective July1,1998, which provides for the involuntary commitment for alcohol or drug treatment of pregnant substance abusing women.[181]

The Commission did not refer to the vulnerability of the fetus in its deliberation of the issue of judicial intervention during pregnancy. On the other hand, Dr. Scorsone included this principle in her description of the dilemma involving judicial intervention during pregnancy:[182]

> The fetus is vulnerable, and is certainly in no position to help herself or himself. One question, then, is whether the woman should be obliged to give the help, obliged, that is, to follow the principles of care for the vulnerable and respect for life, or whether her autonomy is of such prior importance as to be sacrosanct, even in a case in which most people would choose otherwise and would wish that

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[179] Rodgers, *supra* note 31 at 92.

[180] *Ibid.*

[181] S.D. Codified Laws § 34-20A-63 & §34-20A-70 (Michie: 1996 & Supp. 1998).

[182] Report, *supra* note 1 at 1125.

> she, too, would choose otherwise. A second question is what the broader implications of either conclusion would be.

As indicated throughout this chapter, the theme of Dr. Scorsone's dissenting opinion is to challenge the Commission's recommendations by raising questions directed at the relative importance of the guiding principles. Regarding the principle of protection of the vulnerable, the Commission is particularly concerned about the vulnerability of pregnant women. This is a valid concern. However, further consideration is indicated regarding the specific vulnerability of substance addicted pregnant women and their unborn children. Dr. Scorsone's suggestion that judicial intervention during pregnancy may be necessary to address this vulnerability provides excellent direction for further research. That is to say, further study is indicated of the possibility that substance addicted pregnant women need protection from the coercion of addiction in a manner parallel to the legislative intervention designed for people suffering from severe mental illness who are a danger to themselves or others.

Harvard Law Professor Mary Ann Glendon performed a comparative legal analysis to examine "messages about such important matters as life and liberty, individual autonomy and dependency, that are being communicated both expressly and implicitly by abortion regulation."[183] She evaluated France's abortion laws as being particularly instructive because they expressly affirmed the principle of respect for human life. Professor Glendon concluded that France's abortion legislation:[184]

> ...as a whole is pervaded by compassion for pregnant women, by concern for fetal life, and by expression of the commitment of society as a whole to life, and by expression of the commitment of society as a whole to help minimize occasions for tragic choices between them. This commitment is carried out by provision of

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[183] M. A. Glendon, *Abortion and Divorce in Western Law* (Cambridge, Mass.: Harvard University Press, 1987) 15 [hereinafter *Abortion and Divorce*].

[184] *Ibid.* at 18.

> birth control assistance, and by comparatively generous financial support for married as well as unwed mothers.

Examples such as this support Professor Glendon's view that "we must give ourselves the benefit of considering how other liberal pluralistic democracies approach the many vexing legal problems that we have in common,"[185] including prenatal substance abuse.

Professor Glendon's commendable efforts to "resurrect the idea of the law as educational"[186] in matters concerning respect for human life is relevant to decisions concerning the appropriate legal response to substance abuse during pregnancy. As Professor Glendon explained:[187]

> ...in places and times where law is only one of many coexisting systems of social norms-and not the most important one among them-the silence of the law on many subjects is of no particular importance. In societies where the common sense of the community is expressed in various customary, religious, or conventional understandings, it would be redundant to pile legal sanctions on top of social ones. In heterogeneous modern states, however, common values are harder to identify, while law and its official enforcement are more universal and highly developed than other forms of social regulation.... Whether meant to be or not, law is now regarded by many Americans as the principal carrier of those few moral understandings that are widely shared by our diverse citizenry. In these circumstances, legal silences can acquire unintended meanings.

Unfortunately, the Commission failed to adequately consider the law as a mechanism to affirm a commitment to the well-being of both substance addicted pregnant women and the fetus she has decided to carry to term. Clearly, this possibility must be examined prior to any conclusions being reached concerning mandatory treatment for prenatal substance abuse.

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[185] *Rights Talk, supra* note 7 at 146.

[186] *Abortion and Divorce, supra* note 183. The cover includes a commentary by Daniel Casse with this description of Glendon's efforts: "The courageous goal of Mary Ann Glendon's book is precisely to try to resurrect the idea of law as educational..."

[187] *Rights Talk, supra* note 7 at 87.

VII. CONCLUSION

In this chapter, the author has argued that the Commission's recommendations to prohibit judicial intervention during pregnancy are derived primarily from its controversial perception of women's right to reproductive autonomy and equality. The Commission's perceived need to "take special steps to ensure that groups [i.e. women] that have experienced discrimination in the past are placed on an equal footing with other members of society"[188] likely contributed to its aggressive and questionable assertion of these rights. Unfortunately, in so doing, the Commission significantly devalued the principles of respect for human life and protection of the vulnerable in circumstances of substance abuse during pregnancy. It also inappropriately balanced the collective interests of women over and above the individual interests of women.

Although the Commission described its framework for decision making as the ethic of care and guiding principles, the reasons for the recommendations to prohibit judicial intervention during pregnancy essentially boiled down to "rights talk." The Commission's reasoning was directed at promoting women's right to absolute reproductive autonomy. It was directed at promoting the view that approaches to the maternal-fetal relationship that include obligations from women to their fetus is a violation of women's right to equality. Indeed, as the author pondered the many debateable aspects of the Commission's reasons, this highly insightful observation of Professor King rang true:[189]

> Many individuals, especially women, are reluctant to move away from arguments about the maternal-fetal relationship that rest on autonomy and rights-based strategies. Alternative approaches that assume women have obligations to their fetuses are reminiscent of earlier definitions of women's roles and

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[188] Report, *supra* note 1 at 54.

[189] P. King, "Helping Women Helping Children" 1991 (69) 4 The Millbank Quarterly 595 at 604-05.

> responsibilities that served as ways of subjugating women to male domination (Okin 1989). Rights-based strategies were the means that women successfully employed to free themselves from this oppressed condition. Women particularly fear adoption of a view of pregnancy that undermines gains in their right to exercise autonomous reproductive choices.

In the description of its ethical framework, the Commission claimed to be aware of both the positive and negative implications of decision making based on rights:[190]

> We uphold the value of rights. There are many examples of how rights can promote people's self-respect and mobilize them to remedy injustices-the women's movement, the civil rights movement, and the development of human rights instruments through bodies such as the United Nations are among the prime examples. But it is also important to recognize that different people's rights overlap, that rights are subject to various limitations, and that rights usually come with responsibilities attached. To claim a right does not by itself resolve policy issues- or resolve how to assess whether a given claim is indeed a right. Moreover, although rights are important, they can be understood only within a larger context of societal limitations and individual responsibilities.

It is, therefore ironic, that the Commission failed to incorporate this balanced perspective of the value of rights into its decision making process concerning judicial intervention during pregnancy. Rather, the Commission's approach to rights highlighted the negative aspects of rights talk identified by Professor Glendon.[191] The Report reflected inflated political claims with a moral absolutism concerning women's "right" to autonomy and equality and, thereby, encouraged unrealistic expectations.[192] Overall, the Commission's reasoning obstructed the possibility of mutual understanding, mutual benefit, and political compromise because of the focus on self interest and the setting of one right against another. The Commission's examination of judicial intervention during pregnancy was incomplete because it did not adequately address the important concepts of personal, civic and collective responsibilities.[193]

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[190] Report, *supra* note 1 at 61.

[191] *Rights Talk, supra* note 7.

[192] *Ibid.* at x-xi, 14.

Professor Glendon argued that the negative influence of rights talk on public debate and politics is illustrated by American abortion politics. She observed that while almost all European countries have liberalized their abortion laws, they still include some protection for the fetus. Although abortion services are generally relatively easy to access, the legislative framework still communicates respect for human life. Professor Glendon concluded that the European democracies achieved somewhat of a compromise on the abortion issue through consensus-building using the legislative process. To the contrary, Professor Glendon observed that the United States failed in this regard:[194]

> Today, in order to find a country where the legal approach to abortion is as indifferent to unborn life as it is in the United States, we have to look to countries which are much less comparable to us politically, socially, culturally and economically, and where concern about population expansion overrides *both* women's liberty and fetal life. In China, for example, abortion is not punishable at all no matter when it takes place. But this is part of a severe population policy designed practically to compel couples to limit themselves to one child per family.

Professor Glendon's analysis was undertaken shortly after the Supreme Court of Canada handed down its decision in *Morgentaler*. At that time, Professor Glendon suggested that she was anticipating legislative reform to Canada's abortion laws:[195]

> In 1988, the Canadian Supreme Court found that certain aspects of the abortion provisions violated a pregnant woman's "right to security of the person" guaranteed by the 1982 Canadian Charter of Rights and Freedoms. The narrowness of the Court's holding and the generally deferential attitude of the majority judges toward Parliament left the legislature with considerable latitude to fashion a new statute. Throughout 1988, however, Canadian legislators were unable to reach consensus on the issue.

One wonders what would be Professor Glendon's view of the fact that it is now almost a decade later, Canadian legislators have still been unable to reach a consensus on

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[193] *Ibid.* at x. See also Morton, *supra* note 93 at 312 for a discussion of *Rights Talk.*

[194] *Abortion and Divorce, supra* note 183 at 24.

[195] *Ibid.* at 145.

the abortion issue. Morton asked the question of "How much of Glendon's analysis applies to abortion politics in Canada?"[196] He concluded that the non-policy approach to abortion "suggests that the polarizing effects of rights talk is at work in the Canadian body politic."[197] The result being that :[198]

> Canada thus joined, indeed surpassed, the United States as the only Western democracy not to provide at least symbolic support for the unborn child, while still respecting a woman's freedom to choose. Ironically, Canada's new "non-policy" goes even further than Dr. Henry Morgentaler thinks appropriate. Morgentaler believes there is no justification to abort a healthy and viable fetus in a non-threatening pregnancy after the twenty-fourth week of a pregnancy. If rights talk has carried public policy even further than the chief protagonist for the pro-choice side thinks appropriate, this is surely evidence that it has not served Canadians well in this instance.

Similarly, the author has established that the rights talk at work on the recommendations of the Commission has not served Canadians well concerning judicial intervention during pregnancy.

The recommendations of the Commission would certainly give advocates of women's reproductive autonomy "the satisfaction of seeing their convictions implemented as universal practice."[199] However, they could result in grave injustice for some as well as an absolute curtailment of creative problem solving. As declared by Dr. Scorsone:[200]

> In all of these cases, however, a common thread exists. When some, be they embryos, religious groups sponsoring education, women whose complex compulsions and ambivalence about their pregnancies may require judicial elucidation, or anyone else, are made objects subordinated to the collective or individual interests or opinions of others, there is ground for grave injustice, even when the intentions are good. It is better not to drive ahead in ways which, for some, place freedoms and welfare at serious risk or which obliterate those freedoms or that welfare altogether, even when benefit to some others might result or when those who hold a particular view might have the satisfaction of seeing

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[196] Morton, *supra* note 93 at 313.

[197] *Ibid.*

[198] *Ibid.*

[199] *Ibid.*

[200] *Ibid.* at 1142-1143.

> their convictions implemented as universal practice. To do so would be, at its root, both a negation of human rights and, at worst, exploitation. The narrowing of permissible opinion and practice, moreover, would reduce the variability out of which creative insights, adaptations and innovations come.

Canada must rise to the challenge of substance abuse during pregnancy by critically examining legislative schemes utilized or proposed in other jurisdictions, including mandatory treatment for prenatal substance abuse. We must further evaluate the potential for legislative intervention to provide creative approaches to address the problem of substance addiction during pregnancy in a manner that both focuses on the interdependency of mother and fetus and also fosters the dignity of mother, unborn child and the community. Professor Glendon has shown how European countries have "compromised successfully on the abortion issue"[201] by developing legislation that "as a whole is pervaded by compassion for pregnant women, by concern for fetal life, and by expression of the commitment of society as a whole to help minimize occasions for tragic choices between them."[202] If European countries can compromise on the abortion issue which involves an actual conflict, surely, Canada can compromise on the issue of substance abuse during pregnancy which does not involve a conflict. Like Professor Glendon, the author adopts Montesquieu's advice that "The spirit of a legislator ought to be that of moderation, political good...lying always between two extremes." [203] Dr. Scorsone's suggestion that chronic and severe substance addiction may warrant committal in a manner that parallels mental health legislation in severe cases where there is a high risk of harm to the substance abusing pregnant woman and their unborn children is clearly an approach that should be evaluated as a position of " moderation, political good...lying always between two extremes."[204]

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[201] *Abortion and Divorce, supra* note 183 at 19.

[202] *Ibid.* at 18.

[203] *Ibid.* See also Montesquieu, *The Spirit of the Laws,* 11, chap. 29.

Unfortunately, the Report inadequately addressed the issue of civil commitment for severe addiction under a mental health model of legislation. In this regard the Report declared:

> A person can be found mentally incompetent under provincial mental health laws only in a very narrow range of circumstances; drug and alcohol addiction (whether during pregnancy or not) would rarely, if ever, qualify as such a circumstance. The use of mental health legislation to commit or treat a pregnant woman against her will, even where the language of the statute appears applicable, would clearly offend Charter principles.

It is difficult to explain why the Commission failed to note that many countries have some provision for civil commitment; either under mental health legislation or under separate legislation specific to drug use.[205] For example, the Minnesota civil commitment legislation specifically refers to any pregnant woman "who has engaged during pregnancy in habitual or excessive use, for a non-medical purpose" certain controlled substances.[206]

The national debate concerning mandatory treatment for prenatal substance abuse has been "fueled" by the highly publicized Manitoba *DFG*[207] case recently decided by the Supreme Court of Canada and addressed in detail in chapter four. The issues raised in that case are specifically addressed by the work of the Commission concerning judicial intervention during pregnancy and birth. Although the Majority did not condone extending the common law to permit the unborn child to sue its mother for lifestyle choices, it declared almost 20 times that the legislatures, and not the Courts, must address the problem of substance abuse during pregnancy. If legislative intervention was necessarily unconstitutional why would the Court have bother to mentioned it at all, let alone again, and again, and again...? Clearly, the Majority judgment devalues the Commission's conclusion that judicial intervention must be prohibited because a fetus does not have legal status and because women have a constitutional right to autonomy and equality.

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[204] *Ibid.*

[205] Brown, *supra* note 2 at 666.

[206] Minn. Stat. Ann. 7253B.02 subd. 2 (West 1982 & Supp. 1991).

[207] *DFG, supra* note 63.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

In chapter two we argued that substance abuse during pregnancy must be distinguished from situations involving an actual conflict between the pregnant woman and her unborn child. To view the maternal/fetal relationship as adversarial in situations involving substance abuse during pregnancy is unrealistic and counterproductive. As declared by Blank:[1]

> Although there are strong pressures to make the relationship potentially adversarial, generally this approach serves neither party well. The fetus more than a born child needs the mother for its health and life, and many acts of commission and omission by the woman can be injurious to the fetus. Any feasible strategy for dealing with the problems raised here must therefore, place emphasis on the common, shared interests of the mother and fetus, not on the conflicts.

There are many reasons for concluding that mandatory treatment for substance abuse during pregnancy has the potential to promote the shared interests of mother and fetus. However, misconceptions concerning "maternal/fetal conflict," developed largely as a result of "rights talk," and "the legacy of the abortion debate," must be identified and reconsidered before this potential can be properly assessed.

Professor Glendon's comprehensive analysis of "rights talk" provides a particularly insightful and meaningful illustration of the many ways that "rights talk" has impeded "serious and sustained political discussion"[2] of complex social problems, including mandatory treatment for substance abuse. And yet, many individuals and interest groups remain reluctant to move away from rights-based strategies because this was the "means that women successfully employed to free themselves"[3] from the oppression that was reflected in the traditional roles and responsibilities assigned to women based on the assumption that women have obligations to their fetuses. However, history tells us that a rights approach will likely result in a "nonnegotiable deadlock" between the fetus's right to legal protection from substance abuse during pregnancy and the pregnant woman's right to freedom of choice, autonomy and equality. If we are to make progress towards the prevention of substance abuse during pregnancy, we must refine the way we talk and think about the maternal/fetal relationship and substance abuse during pregnancy.

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[1] R. H. Blank, *Mother and Fetus: Changing Notions of Maternal Responsibility* (Westport, CT:Greenwood, 1992) at 157.

[2] M.A. Glendon, *Rights Talk: The Impoverishment of Political Discourse* (New York: The Free Press, 1991) at x [hereinafter *Rights Talk*].

Policy-makers must not be side-tracked by the politically motivated clichés of the rhetoric of the "maternal/fetal conflict" debate. Rather, they must critically re-evaluate this rhetoric from a multi-disciplinary perspective. Indeed, a fundamental element of law reform directed at the prevention of substance abuse during pregnancy is a vigorous partnership between policy- makers and addiction experts. The shared interests of mother and fetus can only be promoted and protected if professionals specializing in addiction, and in particular substance abuse during pregnancy, are consulted early, seriously and continuously in the policy development process. At the root of legislation to prevent substance abuse during pregnancy there must be a commitment to "intervene in the destructive, generational aspects of chemical dependency and family dysfunction."[4]

When addressing the problem of substance abuse during pregnancy, we must acknowledge that the highest levels of government have declared that "drug abuse has become an epidemic that undermines our economic and social fabric."[5] Pregnant women do not choose to abuse substances during pregnancy. Rather, they are responding to the coercion of addiction. We must, therefore, acknowledge that mandatory treatment in extreme cases may be a form of crisis intervention to assist individuals to recover from addiction who would not otherwise accept treatment in a timely manner because of the bondage of addiction: "...the fact remains that many addicts do not enter the treatment system unless they are forced to do so..."[6] We must also consider that such intervention has the potential to break the self perpetuating cycle of addiction relating to dysfunctional parenting skills, and debilitating social circumstances such as abuse, crime, poverty, discrimination and ultimately hopelessness. Finally, we must consider the potential of mandatory treatment to prevent the risk of lifelong and severe damage to future members of our society.

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[3] P. King, "Helping Women Helping Children" (1992) 69 The Millbank Quarterly 595 at 604.

[4] N. Hamilton, "Current Development in Research on the Effects of Prenatal Substance Exposure", in P. Vamos & P. Corriveau eds., *Drugs and Society to the Year 2000* (Montreal: The Portage Program for Drug Dependencies Inc., 1992) 356 at 357.

The argument that mandatory treatment may cause more harm than good, however politically potent it may be, is unpersuasive. A 1995 research paper on mandated and coerced treatment for substance abuse prepared by the Addiction Research Foundation concluded that "policy-orientated arguments about the effectiveness or harm of mandated and coerced treatment do not rest on a solid empirical foundation."[7] Furthermore, proponents of compulsory treatment argue that they have met the burden of justification arising from the fact that this approach involves a diminution in autonomy and liberty rights. By careful reasoning and specific evidence, benefits of compulsory treatment for substance addiction to both the individual and to society have been demonstrated by showing the efficacy of compulsory treatment.[8] Finally, we must acknowledge that mental health legislation mandating involuntary hospitalization of individuals suffering from severe mental illness, and determined to be a danger to themselves and others, has not functioned to unjustly and arbitrarily authorize involuntary treatment of those suffering from milder degrees of mental illness. Nor has it been established that this legislation is counterproductive by encouraging people with mental illness to avoid health care.

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[5] P. Erickson, "Recent Trends in Canadian Drug Policy: The Decline and Resurgence of Prohibitionism" (1992) 121 Daedalus 239.

[6] J. Platt et. al., "The Prospects and Limitations of Compulsory Treatment for Drug Addiction" (1988) 18 (4) The Journal of Drug Issues 505 at 511.

[7] Mandated Treatment and Coercion Working Group, by C. Wild et al., Social Evaluation and Research Department, Addiction Research Foundation, *Mandated and Coerced Treatment for Substance Abuse: Current Knowledge and Future Research Directions* (Toronto: Addiction Research Foundation of Ontario, 1995).

Contrary to what the literature on "maternal/fetal conflict" reveals, civil commitment for severe addiction is covered under mental health legislation or under legislation specific to drug abuse in many countries.[9] For example, in 1989, the *Minnesota Commitment Act* was amended to specifically include pregnant women addicted to certain controlled substances.[10] Clearly, it is arguable that this legislation has shortcomings in relation to the specific problem of substance abuse during pregnancy. It does not include alcohol abuse, which is the cause of Fetal Alcohol Syndrome and the "leading cause of mental disability in the western world."[11] Furthermore, it does not address the unique needs of women and their children in alcohol and drug recovery programs which are broader than offered by typical alcohol and drug recovery services including; the need for child care, "basic medical care, HIV testing and counseling, vocational training, remedial education psychiatric service for dual diagnosis, leisure time activities, life skills training, self-help groups, parenting classes and money management."[12] However, it is a useful framework to examine in that it is pregnancy specific and is based on a mental health framework which includes procedural safeguards designed to protect the civil rights of individuals suffering from addiction. More recently, South Dakota passed legislation which provides for involuntary commitment for alcohol or drug treatment of pregnant substance abusing women.[13]

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[8] L. Gostin, "Compulsory Treatment for Drug-dependent Persons: Justifications for a Public Health Approach to Drug Dependency" (1992) 69 The Millbank Quarterly 561 at 561.

[9] B. Brown, *Civil Commitment-An International Perspective* (1988) 18 (4) The Journal of Drug Issues 663 at 666.

[10] Minn. Stat. Ann. § 253B. 02 subd. 2 (West 1982 & Supp. 1991).

[11] The Manitoba Children and Youth Secretariat, *Strategy Considerations for Developing Services for Children and Youth* (March 1997) at 15.

Chapter three, which entails a critical analysis of the *DFG*[14] case, provides a graphic illustration of the all too common tragedy of substance abuse during pregnancy for women and children. In light of the case history of Ms. G. and her children, it becomes impossible to reasonably argue that we must protect a severely addicted pregnant woman's "freedom of choice" and "right" to abuse substances during pregnancy. Rather, law reformers must respond to the Supreme Court of Canada's demand for the legislatures to address the problem of substance abuse during pregnancy. In so doing, they must address the types of intervention specifically contemplated by the Majority.

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[12] C. Roob Jane,"Perinatal Addiction", in P. Vamos & P. Corriveau eds., *Drugs and Society to the Year 2000,* (The Portage Program for Drug Dependencies Inc., 1992) 937 at 944 [hereinafter "Perinatal Addiction"].

[13] S.D. Codified Laws § 34-20A-63 & § 34-20A-70 (Michie: 1996 & Supp. 1998)

[14] *Winnipeg Child and Family Services (Northwest Area)* v. *G. (D.F.)* [1996] M.J. No. 386 (QL), 111 Man. R. (2d)219, 138 D.L.R. (4th) 238, 10 W.W.R. 95, rev'd [1996] M.J. No. 398 (QL) (Man. C.A.), 138 D.L.R. (4th) 254, rev'd [1997] 3 S.C.R. 925, S.C.J. No. 96 (QL) [hereinafter *DFG* cited to (1997) S.C.J. No. 96 (QL)].

In the context of the general proposition that the law of Canada does not recognize the unborn child as a legal or juridical person, law reformers must respond to the Majority's observation that:[15]

> If Parliament or the legislatures wish to legislate legal rights for unborn children or other protective measures, that is open to them subject to any limitations imposed by the Constitution of Canada.

In the context of the "slippery slope" argument that "having broken the time-honored rule that legal rights accrue only upon live birth, the courts would find it difficult to limit application of the new principle to particular cases",[16] law reformers must address the Majority's observation that:[17]

> By contrast, the legislature, should it choose to introduce a law permitting action to protect unborn children against substance abuse, could limit the law to that precise case.

In the context of the Majority's examination of the argument that the "live-birth" rule should be overturned because the present law does not provide a remedy for situations like the case at bar, law reformers must respond to the observation that:[18]

> It is not every evil which attracts court action; some evils remain for the legislature to correct.

In the context of the Majority's conclusion that the *parens patriae* jurisdiction should not be extended to protect the unborn child, law reformers must address the Majority's observation that:[19]

> If a pregnant woman was to be subject to controls for the benefit of her unborn child, Parliament should so legislate, as it had in the case of mentally incompetent persons.

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[15] *Ibid.* at para. 12.

[16] *Ibid.* at para. 24.

[17] *Ibid.*

[18] *Ibid.* at para. 26.

[19] *Ibid.* at para. 53.

The critical examination of the recommendations of the Royal Commission on New Reproductive Technologies (hereinafter the Commission) undertaken in chapter four argued that they are based on inadequate legal and ethical reasoning and must, therefore, be rejected. In our search for an alternative legislative response to the problem of substance abuse during pregnancy, law reformers must respond to the many issues raised in Dr. Scorsone's dissenting opinion. Is "... severe drug addiction resulting in incoherence or uncontrollable compulsion ... sufficiently parallel to or cognate with severe mental illness in some respects that similar approaches are appropriate"[20]? Does mandatory treatment for substance abuse during pregnancy have the potential to operate in "defense of a woman's best interests, actual intent and consent, and thus her authentic autonomy, against the coercion she experiences from some other factor in her life, such as severe drug addiction"[21]? Is it appropriate to deem a woman "responsible for the environment she provides the one who is there at her initiative, even as the employer is responsible for the environment he or she provides for the employee who is there at his or her initiative?[22] What are the implications for law reform arising from the view that:[23]

> As only a woman can, by her own drug abuse or other actions, severely handicap someone for life, only a man can rape. That only one gender can do one or the other form of harm does not make accountability for either discriminatory. The single standard of behavior pertains to both.

The current rhetoric of "rights talk," so strongly reflected in the Commission's legal and ethical reasoning to support its decision to prohibit judicial intervention during pregnancy, emphasizes the need to redevelop our way of thinking and talking about the maternal/fetal relationship. We must redirect our focus from the fetus to the child who will be born. We must also focus on his or her home and family environment which will determine, in part, whether he or she will or will not be nurtured so as to become a contributing and fulfilled member of society. Finally, we must also redirect our focus from the pregnant addict to the great ills within our society that are the root causes of addiction. In short, our strategies must be comprehensive meaning that we must:[24]

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[20] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) at 1127 [hereinafter "Report"]. Dr. Scorsone's dissenting view is presented on pages 1123-24 of vol. 2 of the Report.

[21] *DFG, supra* note 14 at 1126.

[22] *Ibid.* at 1131.

[23] *Ibid.* at 1131-32.

> ...focus on collaborative relationships among community leaders, organizations, and institutions, establishing community norms of nonuse as the ideal. Comprehensiveness also means taking into account the complex causes of alcohol and drug use recognizing that individual, family, peer group, community and social factors contribute to the problem and addressing a variety of these factors, not just one or two in isolation.

This description of a comprehensive approach to perinatal addiction is consistent with Professor Glendon's view that we must nurture the seedbeds of civic virtue "which presently are not in peak condition."[25] While it is agreed that mandatory treatment is a remedy of last resort, its potential to break the intergenerational nature of addiction and the individual suffering caused by substance abuse during pregnancy must be critically examined. This is vital to the process of weeding our seedbeds of those impediments that "work against the conditions required for the pursuit of dignified living by free women and men."[26]

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[24] Perinatal Addiction, *supra* at note 13.

[25] *Rights Talk*, *supra* note 2 at xi.

[26] *Ibid.*

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